

**COLUMBIA**

**COLLEGE**

Health Services Clinic  
1001 Rogers Street  
Columbia, MO 65216  
Phone: 573/875-7432  
FAX: 573/875-7235  
E-mail: [dketter@ccis.edu](mailto:dketter@ccis.edu)

Name: \_\_\_\_\_  
Last First Middle  
Local Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
CC Email: \_\_\_\_\_  
Student ID: \_\_\_\_\_ Birth Date: \_\_\_\_\_

**INSTRUCTIONS:** This form **must** be completed and immunization records submitted in order to register for classes. Two MMRs (Mumps, Measles, and Rubella) are required. Immunization records can be obtained from your previous school or family physician.

**TUBERCULOSIS SCREENING:** Tuberculosis screening (PPD) is **required** for all international (non-USA) students and is to be done upon arrival in the United States.

**MENINGOCOCCAL VACCINATION** required for all students living in residence halls.

**Do you plan to live in the residence halls?** \_\_\_ Yes \_\_\_ No

Meningococcal Vaccine date \_\_\_\_\_ or waiver signed by student or parent if student is under 18.

**Waiver: I received information about meningitis but choose not to receive the immunization at this time.**

**Printed name** \_\_\_\_\_ **Signature** \_\_\_\_\_  
Of Student or Parent/Guardian if applicable **Date** \_\_\_\_\_

**EXEMPTION:** from mandatory immunization policy is requested based upon the following reason:

- MEDICAL EXEMPTION: Reason \_\_\_\_\_
- RELIGIOUS EXEMPTION: Reason \_\_\_\_\_

**PERSONAL HEALTH HISTORY:**

Allergies to Medicines: \_\_\_\_\_

Plants, Pollens, Bees or other: \_\_\_\_\_

List current prescriptions with dosages \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently being treated by a health care professional? If yes, explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Check all that apply now or in the past. Explain any "yes" answers as needed, and provide additional records from your doctor if these records are needed to continue your care while at Columbia College.

- |                     |                         |                        |                     |
|---------------------|-------------------------|------------------------|---------------------|
| ___ Alcohol Abuse   | ___ Gallbladder Problem | ___ Migraines          | ___ Sinus Problems  |
| ___ Anemia          | ___ Hay Fever           | ___ Mononucleosis      | ___ Sleep Problems  |
| ___ Asthma          | ___ Head Injury         | ___ Mumps              | ___ Smoke           |
| ___ Back Problems   | ___ Hearing Loss        | ___ Paralysis          | ___ STD             |
| ___ Cancer          | ___ Heart Problem       | ___ Pneumonia          | ___ Surgery         |
| ___ Depression      | ___ Hepatitis           | ___ Polio              | ___ Thyroid Problem |
| ___ Diabetes        | ___ Hernia              | ___ Psych Counseling   | ___ Tuberculosis    |
| ___ Drug Abuse      | ___ High Blood Pressure | ___ Rheumatic Fever    | ___ Urinary Problem |
| ___ Eating Disorder | ___ Joint Problem       | ___ Sickle Cell Anemia | ___ Other _____     |
| ___ Eye Problem     | ___ Meningitis          | ___ Seizure Disorder   | _____               |

Explanation of Checked Conditions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any physical or learning disabilities? \_\_\_Yes \_\_\_No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HEALTH INSURANCE INFORMATION:** Do you have health insurance? \_\_\_Yes \_\_\_No

**PERSONS TO NOTIFY IN EMERGENCY**

Name & Address	Relationship: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____
Name & Address	Relationship: _____ Cell Phone: _____ Work Phone: _____ Home Phone: _____

**PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES:** I hereby authorize the Medical and Mental Health Staff of Columbia College, their agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at Columbia College. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person designated to notify in case of emergency will be notified if considered necessary by the professional staff at Columbia College.

\_\_\_\_\_  
Signature of Student (or Parent/Guardian if student is under 18 years of age.)

\_\_\_\_\_  
Date