UAF Health Inventory

PLEASE RETURN COMPLETED FORM TO UAF HEALTH CENTER

Please complete all information and print all information clearly

Name____ Male/Female Today's date: ________________

Last, First, Middle

Date of Birth_______________________________ UAF Student ID#__________________________

Local Address: ____ Phone ( ) __________________

City State Zip Code

Permanent Address: ____ Phone ( ) __________________

City__________________________ State__________________ Zip Code______________________

Insurance Company Name: ____

Emergency Contact:

Name: ____________________________________

Relationship: ______________________________

Adddress: _________________________________

Phone/Fax: ________________________________

Please list any medications you take:

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Family Health History (blood relative)

Diabetes ________________________________

High Blood Pressure _______________________

Stroke __________________________________

Cancer (type) ____________________________

Heart attack before age 60 __________________

High Cholesterol __________________________

other significant conditions ________________

Please list any allergic or adverse reactions:

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Have you ever had or do you currently have: *Check All That Apply*

	Yes	Year		Yes	Year		Yes	Year
Serious skin disease			Used laxatives, diuretics or self-induced vomiting to control weight			**For Men**		
Tumor or cancer			Anorexia nervosa			Sexually Transmitted disease		
Eye trouble other than need for glasses			Binge eating episodes more than once per week (bulimia)			Testicular problem		
Hearing loss			Ulcer (duodenal or stomach)			Do you practice testicular exam		
Ear, nose & throat trouble			Nausea/vomiting/diarrhea			**For Women**		
Sinusitis			Jaundice & hepatitis			Menstrual Problems		
Thyroid trouble			Mononucleosis			Breast problems		
Hay fever			Gall bladder trouble/gallstones			Do you practice breast exam		
Shortness of breath			Hernia			Pelvic inflammatory disease		
Asthma			Rectal disease/hemorrhoid			Sexually transmitted disease		
Pneumonia			Kidney stone			Ovarian cysts		
Chronic cough			Swollen or painful joints			Abnormal pap smear		
Tuberculosis			Arthritis, rheumatism or bursitis			Serious depression		
Positive tuberculin skin test			Neck or back problems			Excessive worry or anxiety		
High blood pressure			Concussion (severe head injury)			Have you tried to commit suicide		
Rheumatic fever			Frequent or severe headaches			DES exposure in utero		
Heart trouble			Dizziness or faulty speech			Sleep disturbance		
Abdominal Pain			Epilepsy					
Diabetes			Anemia or blood disorder					

Please comment on any yes responses. (List dates/location of any hospitalizations, surgeries, severe injuries) **Do you have other health concerns that we should know about?** *Attach another sheet if necessary*

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Student Signature: ______________________________________ Date: ____________________

RECORD OF REQUIRED IMMUNIZATIONS

PROOF OF REQUIRED IMMUNIZATION IS MANDATORY FOR ALL STUDENTS AT UAF. THIS FORM SIGNED BY A CLINICIAN OR A COPY OF YOUR MEDICAL RECORD OF IMMUNIZATIONS MUST BE COMPLETED AND RETURNED TO THE CENTER FOR HEALTH & COUNSELING PRIOR TO MATRICULATING.

There are many possible sources for obtaining your immunization record if it is not in your possession: your high school or previous college, your local health department if you received immunizations there, your military immunization record or from your pediatricians office or parents.

TUBERCULOSIS (PPD) SKIN TEST	Date	Results	Date must be within one year of UAF admission. If TB test is positive a chest X-ray is required.
BCG IF APPLICABLE CXR	Date	Results	Send report of chest x-ray done within last year.
TETANUS, DIPHTHERIA, PERTUSSIS - PRIMARY SERIES COMPLETED.	Month	Year	If serious doubt exists about the completion of a primary 3 dose series, 2 doses of 0.5 ml of combined (Td) toxoids should be given one month apart, followed by a third dose in 6-12 months.
TETANUS, DIPHTHERIA BOOSTER	Month	Year	Must be within the past 10 years.
POLIOMYELITIS SERIES COMPLETED.	Month	Year	Not required of students age 17 or older.
MUMPS	Month	Year	Recommended for students born after 1956.
MEASLES/RUBEOLA	Month	Year	Persons born before 1957 do not need this immunization. Live virus vaccine must have been administered after 1968 and given after 12 months of age. Laboratory evidence of immunity is acceptable.
RUBELLA/GERMAN MEASLES	Month	Year	Live virus vaccine must have been administered after 1968 and given after 12 months of age. Laboratory evidence of immunity is acceptable.
2ND DOSE MMR	Month	Year	A second dose is recommended.

Certification of Dates of Immunization and Freedom from Active Tuberculosis

Signature of Clinician or Public Health Official ______________________

DATE

Printed name and address ______________________

Student Signature ______________________

DATE

IF STUDENT IS UNDER 18 YEARS OF AGE

I hereby give the Center for Health & Counseling permission to give my son/daughter medical treatment and/or appropriate immunizations.

Parent or Guardian signature ______________________

DATE

PLEASE RETURN THIS FORM WITH BOTH SIDES COMPLETED TO:	UAF Student Health & Counseling Center Whitaker Bldg. 2nd Floor P. O. Box 755580, Fairbanks, Alaska 99775-5580