OHIO CHRISTIAN UNIVERSITY

Health and Immunization Record

Name (Last, First, M.I.):	☐ M ☐ F	**DOB:**
Social Security #:		
Address:		
Health Insurance Co.:	**Policy Number:**	
Family Physician:	**Physician Phone:**	
Physician Address:		
Date of last Physical Exam:		
Family Dentist:	**Dentist Phone:**	
Dentist Address:		
Date of last Dental Exam:		
Primary Emergency Contact:		
Address:		
Relationship to Student:	**Mobile Phone:**	
Home Phone:	**Work Phone:**	
Secondary Emergency Contact:		
Address:		
Relationship to Student:	**Mobile Phone:**	
Home Phone:	**Work Phone:**	

PERSONAL HEALTH HISTORY STATEMENT (to be completed by student)		
Medical Condition	**Circle One**	**If yes, please explain:**
Physical Disability	Yes No	
Learning Disability*	Yes No	
Physical Activity Restriction	Yes No	
Other	Yes No	

*If you have a diagnosed learning disability and you feel as if you need or desire accommodations, please consult the 504 Compliance Officer at complianceofficer@ohiochristian.edu.

I agree that all information given is accurate to the best of my knowledge. Further, I give permission for the health care professional(s) listed above to release the required information to Ohio Christian University.

Signed: Date:

Please return completed record to: Ohio Christian University, Admissions Office, 1476 Lancaster Pike, Circleville, Ohio 43113

Development Guidelines, recommendations and requirements provided by The American College Health Association, Baltimore, MD 21240. www.acha.org

OHIO CHRISTIAN UNIVERSITY

Immunization Record

PROFESSIONAL HEALTH HISTORY STATEMENT (to be completed by health care professional)					
Medical Condition	**Circle One**	**If yes, please explain:**			
Heart Abnormality	Yes No				
Vision Abnormality	Yes No				
Disabilities or Handicaps	Yes No				
Physical Activity Restriction	Yes No				
Childhood illness: ☐ Measles	☐ Mumps	☐ Rubella	☐ Chickenpox	☐ Rheumatic Fever	☐ Polio
Immunization	**Series Dates**				**Last Vaccination**
Hepatitis B*					
Meningococcal*					
MMR (Measles, Mumps, Rubella)*					
DTaP/DTP*					
Varicella*					
Polio*					
Influenza**					
Tuberculosis*					

* Required immunizations. Students with immunodeficiency such as complement deficiency or asplenia should receive the meningococcal vaccine every 3-5 years.

**Annual immunization recommended to avoid disruption of academic activities.

Immunization Notes (Please list any pertinent information related to vaccinations and/or reactions.)

Tuberculosis Screening	**Circle One**	**If yes, please explain**	
Sign/Symptoms	Yes No		
High Risk	Yes No		
Skin Test Performed	Yes No	Date:	Date Read:
		Result:	Interpretation: ☐ Positive ☐ Negative
Chest X-Ray Required	Yes No	Date:	Interpretation: ☐ Normal ☐ Abnormal

Additional Medical Consideration/Comments

Healthcare Provider	
Name:	**Phone:**
Signed:	**Date:**

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