

# BRADLEY UNIVERSITY

# REQUIRED STUDENT HEALTH FORM

819 N. Glenwood Ave, Markin Center – Bradley University, Peoria, IL 61625 Ph:(309)677-2700 Fax:(309)677-3534

SEMESTER ENTERING YEAR \_\_\_\_\_ FA \_\_\_ SP \_\_\_ FR. SO. JR. SR. GRAD. BRADLEY ID# \_\_\_\_\_

PLEASE PRINT OR TYPE:

NAME \_\_\_\_\_  
(LAST, FAMILY SURNAME) (FIRST, GIVEN) (MIDDLE, OTHER)

BIRTH DATE: \_\_\_/\_\_\_/\_\_\_ MALE \_\_\_ FEMALE \_\_\_ SOCIAL SECURITY NUMBER \_\_\_-\_\_\_-\_\_\_  
MO DAY YR

HOME ADDRESS \_\_\_\_\_  
STREET

CITY STATE ZIP  
PHONE (\_\_\_\_) \_\_\_\_\_ STUDENT CELL PHONE (\_\_\_\_) \_\_\_\_\_

## PAST MEDICAL HISTORY

DRUG ALLERGIES \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

HOSPITALIZATIONS OR SURGERIES \_\_\_\_\_

MEDICAL CONDITIONS \_\_\_\_\_

MENTAL HEALTH ILLNESSES \_\_\_\_\_

**PLEASE INCLUDE A COPY OF YOUR HEALTH INSURANCE CARD  
OR SUMMARY INSURANCE POLICY**

IN THE EVENT I WOULD NEED OUTPATIENT LABS, DIAGNOSTIC STUDIES, OR EMERGENCY SERVICES DONE AT ONE OF THE  
LOCAL AREA HOSPITALS, I AUTHORIZE BRADLEY HEALTH SERVICES TO UTILIZE:

**OSF ST. FRANCIS**

**METHODIST**

**PROCTOR**

PLEASE CHECK WITH YOUR INSURANCE COMPANY REGARDING COVERAGE IN THE PEORIA AREA

IN CASE OF MEDICAL OR PSYCHIATRIC EMERGENCY OR HOSPITALIZATION, I AUTHORIZE BRADLEY STUDENT HEALTH SERVICES  
TO NOTIFY: \_\_\_\_\_ PHONE \_\_\_\_\_

PARENTS: MOTHER \_\_\_\_\_ HOME PH (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CELL PH (\_\_\_\_) \_\_\_\_\_

FATHER \_\_\_\_\_ HOME PH (\_\_\_\_) \_\_\_\_\_

ADDRESS \_\_\_\_\_ CELL PH (\_\_\_\_) \_\_\_\_\_

SIGN HERE \_\_\_\_\_ DATE \_\_\_\_\_

STUDENT SIGNATURE

ATTENTION PARENT/GUARDIAN OF MINOR STUDENTS (students under the age of 18):

I give my permission for the medical staff of Bradley University Student Health Center to diagnose and treat medical conditions that may arise while my child is attending Bradley University.

SIGN HERE \_\_\_\_\_ DATE \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE

**IMMUNIZATION HISTORY**

**STUDENT'S NAME:** \_\_\_\_\_

**IF YOUR BIRTH DATE IS BEFORE JANUARY 1, 1957, PLEASE CONTACT HEALTH SERVICES AT 309-677-2700.**

**SECTION 1: REQUIRED BY THE STATE OF ILLINOIS**

TETNUS/DIPHThERIA DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MUST BE CURRENT WITHIN THE LAST TEN YEARS) MO DAY YR

MMR DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
(MEASLES, MUMPS, RUBELLA) **TWO** DOSES REQUIRED AFTER 1<sup>ST</sup> BIRTHDAY

PROOF OF IMMUNITY MAY ALSO BE PROVIDED BY A COPY OF THE STUDENT'S HIGH SCHOOL HEALTH RECORD WHICH COMPLIES WITH THE IMMUNIZATION REQUIREMENTS OF THE STATE OF ILLINOIS. OTHERWISE, ALL IMMUNIZATION DATES MUST BE VERIFIED BY YOUR PHYSICIAN OR HEALTH CARE PROVIDER

**SECTION 2: ONLY IF SECTION 1 IS NOT COMPLETED**

MEASLES (RUBEOLA) – 2 DOSES AFTER 1<sup>ST</sup> BIRTHDAY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
OR DATE OF DISEASE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ OR TITER (LAB COPY REQUIRED) DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

RUBELLA – FIRST DOSE REQUIRED AFTER 1<sup>ST</sup> BIRTHDAY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
OR TITER (LAB COPY REQUIRED) DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

MUMPS – FIRST DOSE REQUIRED AFTER 1<sup>ST</sup> BIRTHDAY DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
OR DATE OF DISEASE DATE \_\_\_\_/\_\_\_\_/\_\_\_\_ OR TITER (LAB COPY REQUIRED) DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

A STUDENT MAY BE EXEMPTED BY THE HEALTH CENTER IF A WRITTEN STATEMENT FROM THE STUDENT (OR GUARDIAN, IF THE STUDENT IS A MINOR) DETAILING OBJECTION TO IMMUNIZATION ON GROUNDS THAT THEY CONFLICT WITH TENETS OR PRACTICES. GENERAL PHILOSOPHICAL OR MORAL OBJECTION TO IMMUNIZATION SHALL NOT BE SUFFICIENT FOR AN EXEMPTION ON RELIGIOUS GROUNDS.

**PHYSICIAN/HEALTH CARE PROVIDER SIGNATURE:** \_\_\_\_\_  
**NAME (PRINT)** \_\_\_\_\_ **BUSINESS PHONE:** \_\_\_\_\_

**SECTION 3: TUBERCULOSIS (TB) SCREENING REQUIRED BY BRADLEY UNIVERSITY**

- CHECK ANY THAT APPLY:
- \_\_\_\_ FROM OR HAVE LIVED FOR TWO MONTHS OR MORE IN ASIA, AFRICA, CENTRAL, OR SOUTH AMERICA OR EASTERN EUROPE
  - \_\_\_\_ HAVE BEEN DIAGNOSED WITH A CHRONIC MEDICAL CONDITION THAT MAY IMPAIR YOUR IMMUNE SYSTEM
  - \_\_\_\_ A HEALTH CARE WORKER
  - \_\_\_\_ A VOLUNTEER OR EMPLOYEE OF A NURSING HOME, PRISON, OR OTHER RESIDENTIAL INSITUATION
  - \_\_\_\_ CONTACT WITH A PERSON KNOWN TO HAVE ACTIVE TUBERCULOSIS
  - \_\_\_\_ NONE OF THE ABOVE APPLY

IF ANY OF THE ABOVE DO APPLY, TB SCREENING IS REQUIRED. OPTIONS ARE AS FOLLOWS:

- 1.) SCHEDULE AN APPOINTMENT AT STUDENT HEALTH FOR PPD SCREENING TEST
- 2.) PROVIDE DOCUMENTATION OF NEGATIVE TB SKIN TEST DONE IN THE UNITED STATES WITHIN THE LAST 12 MONTHS PPD TEST DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
MILLIMETERS INDURATED \_\_\_\_MM POS \_\_\_\_ NEG \_\_\_\_
- 3.) PROVIDE DOCUMENTATION OF PRIOR TREATMENT OF ACTIVE TB DISEASE

**SECTION 4: RECOMMENDED BY BRADLEY UNIVERSITY (NOT REQUIRED)**

HEPATITIS B #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
HPV (GARDASIL) #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
MENINGOCOCCAL VACCINE (MENACTRA) \_\_\_\_/\_\_\_\_/\_\_\_\_  
CHICKEN POX DISEASE YES \_\_\_\_ NO \_\_\_\_ VACCINE: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ AND #2 \_\_\_\_/\_\_\_\_/\_\_\_\_