



MESSENGER COLLEGE

HEALTH FORM

300 E. 50th Street ~ Joplin, MO 64804
417.624.7070 ~ 800.385.8940

The Health Form is for use by the Messenger College Administration. The contents of this record are confidential and will not be released without your written consent. Please complete this form in its entirety. It is not necessary to see a doctor to complete this form unless you will need additional immunizations or a Tuberculin (TB) Skin Test.

Student Information

Please TYPE or PRINT your answers.

NAME: _____ SS#: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____

Immunization History

Meningitis	Completed	<input type="radio"/> Yes	<input type="radio"/> No	Date of Last Injection	_____
Measles/Mumps/Rubella	Completed	<input type="radio"/> Yes	<input type="radio"/> No	Date of First Injection	_____ Date of Last Injection _____
Polio	Completed	<input type="radio"/> Yes	<input type="radio"/> No	Date of Last Injection	_____
Tetanus	Completed	<input type="radio"/> Yes	<input type="radio"/> No	Date of Last Injection	_____
Diphtheria	Completed	<input type="radio"/> Yes	<input type="radio"/> No	Date of Last Injection	_____

A current Tuberculin (TB) Skin Test is REQUIRED within the last year.

Tuberculin Skin Test Date of test _____ Results _____

Chest X-Ray (If TB Skin Test is positive) Date of test _____ Results _____

Signature of Health Care Professional: _____

Health Profile

ALLERGIES: Penicillin Sulfa Drugs Aspirin Latex

Other: _____

List any hospital stays you have had:
Length Reason

List any surgeries you have had (inpatient and outpatient)
Date Reason

List any medications you are currently taking: _____

Do you have, or have been diagnosed with, any of the following conditions? If so, please attach a separate sheet with detailed explanation.

- | | | |
|--|--|--|
| <input type="radio"/> Excessive feelings of loneliness | <input type="radio"/> Anorexia or Bulimia | Have you ever been prescribed psychiatric/mood altering medication? If so, please explain _____
_____ |
| <input type="radio"/> Excessive worry or nervousness | <input type="radio"/> Alcoholism | |
| <input type="radio"/> Depression or excessive sadness | <input type="radio"/> Drug Addiction/Abuse | |
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Learning Disability | |

CONSENT FOR TREATMENT

Consent is hereby given for treatment by a health care provider of choice for routine health care, assessment, diagnosis, treatment, and if necessary, hospitalization. It is understood that the College will contact the next of kin as soon as possible in the case of an emergency.

Signature of Student: _____ Date: _____

Parent or guardian must also sign if the student is single and under 18 years of age at the time this form is submitted to the College.

Parent or Guardian: _____ Date: _____