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

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**						

* 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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