

ST. NORBERT COLLEGE HEALTH AND WELLNESS SERVICES

Health Form

This record is confidential.★

SECTION A

Name _____ DOB _____ Student's Cell Phone _____

Email address SNC: _____ Other: _____

Permanent/Home Address _____

Emergency Notification Name _____ Ph. (H) _____ Cell _____

A medical exam is required only if an on-going medical condition exists.

Personal Health History

SECTION B

CHILDHOOD DISEASES	Yes
a. Chicken Pox	
b. Mono	
c. Other	

CHRONIC OR CONTINUING HEALTH CONCERNS	
a. Abnormal bleeding tendency	
b. Alcohol/substance abuse	
c. Anemia	
d. Asthma	
e. Cancer	
f. Convulsions or seizures	
g. Depression, anxiety, bipolar	
h. Diabetes	
i. Diseases of colon/intestinal tract	
j. Eating Disorder	
k. Heart disease/cardiac concerns	
l. High blood pressure	
m. Kidney disease	
n. Orthopedic problems	
o. Psychiatric hospitalization	
p. Severe or frequent headaches	
q. Suicidal thoughts/ideations	

CHRONIC OR CONTINUING HEALTH CONCERNS (cont.)	Yes
r. Thyroid	
s. Trauma	
t. Other	
u. Current Medications (Please list)	Dosage
v.	
w.	
x.	

ALLERGIES / Check & list below

None known	
Allergic to:	Type
Medication	
Food	
Plants/seasonal/envIRON.	
Insect bites (type)	
Other	

**IF YOU HAVE A DISABILITY FOR WHICH YOU NEED ACCOMMODATIONS
PLEASE REGISTER WITH THE DISABILITIES OFFICE ON CAMPUS:
www.snc.edu/academicsupport OR CALL THE OFFICE AT
(920)403-1321.**

If you answered "Yes" to any of the above, please identify condition and dates of treatment: _____

If you are receiving treatment for any physical or psychological condition, please attach current plan of care including your provider's name and contact information

Family History

Please list any significant family medical history and relationship to you _____

IMMUNIZATIONS

NAME: _____ DOB _____

ALL IMMUNIZATION RECORDS MUST BE TRANSFERRED TO THIS HEALTH FORM BY THE STUDENT OR PARENT TO BE CONSIDERED A PART OF THIS MEDICAL RECORD. ATTACHED COPIES OF IMMUNIZATION DATES WILL NOT BE ACCEPTED.

SECTION C

Required Vaccines	Type	Dose	Date (MM/DD/YY)	Recommended Vaccines	Dose	Date (MM/DD/YY)		
DTP		1		Hepatitis B	1			
		2			2			
		3			3			
		4						
		5		Menactra or Menomune	Dose			
		Dose			1			
Td		1						
Td		2						
Tdap (Adult Tetanus/Diphtheria/Pertussis)		1		Other Vaccines				
	Type	Dose		Hepatitis A	Dose			
Polio (specify OPV or IPV)		1			1			
		2			2			
		3						
		4		Varicella (Chicken Pox)	Dose			
		5			1			
	Type	Dose			2			
Measles/Mumps/ Rubella (MMR) (2 doses are required)		1						
		2		HPV Vaccine (Gardasil)	Dose			
TB Questionnaire completed					1			
*Note: For individuals with medical contraindications or religious convictions related to the required immunizations, please contact Health and Wellness Services at (920)403-3266					2			
					3			
				Other Vaccines Received				

SECTION D

WISCONSIN STATE LAW (ASSEMBLY BILL 344) REQUIRES STUDENTS TO SIGN AN ACKNOWLEDGEMENT STATEMENT RELATED TO HEPATITIS B AND MENINGITIS. PLEASE REFER TO ENCLOSED MENINGOCOCCAL DISEASE AND HEPATITIS B INFORMATION SHEET.

My signature below verifies receipt of the hepatitis B and meningitis information. The information herein is true and correct.

Signature _____ Date _____

★The information on this form is for the confidential use of the St. Norbert College Health and Wellness clinical staff. The HIPAA Privacy Notice is available on the SNC website listed below. Health information is released only through written consent by the student who is 18 years or older.

Phone Number (920)-403-3266
 Fax: (920)403-3099
 Web site: www.snc.edu/health

St. Norbert College Health and Wellness Services
 100 Grant Street
 De Pere WI 54115