New Student Health Form

All sections required. Please complete in ink.
Instructions on how to submit this form are in SECTION G.

A

MEDICAL INFORMATION

Student Full Name: ________________________ Date of Birth _____/______/______

Height ________Weight ______ Social Security Number ___________________

FALL START   SPRING START   START YEAR: ________

If you have attended CIU in the past, please list year: _______

Permanent Address __________________________ City ________________ ST ______

Phone ______________________

B

EMERGENCY CONTACT INFO

Name: ____________________________ Relationship _____________________

Phone: ____________________________ Email: _________________________

City: ______________________________ State: _________________________

C

IMMUNIZATIONS (Required if born after 1956)
Include a copy of your immunization record OR immune blood test results with this form.

REQUIRED
Ŋ NNS (Nfbtmft, Nvnqt, Svcfmmb) - Must be 2 doses, 30 days apart, after 1st Birthday

RECOMMENDED
Ŋ Ifqbujuvt C   Ŋ Qpmjp   Ŋ Nfojohjujt   Ŋ Wbsjdfmmb (Dijdlfo Qpy)
Ŋ Ufubovt Ejqiuifsjb-Qfsuvttjt (xjuijo uif qbtu 10 zfbst)

Check here if you have included a copy of your records.

D

TUBERCULOSIS SCREENING - MUST BE COMPLETED BY HEALTH CARE PROVIDER
Ŋ UC tljo uftu ps cmppe uftu jt sfrvjsfe boe nvtu cf xjuijo pof zfbs qsjps up fospmmnfou bu DJV.

Check here if you are attaching a copy of a report instead of having a doctor complete below.

DATE GIVEN _________ DATE READ __________ RESULT (report actual mm): _________

Negative   Positive

IF POSITIVE: Chest XRAY required.

XRAY RESULT: Normal   Abnormal   Date __________ (Provide copy of report)

____   ____________   ___________
Physicians Signature or Health Department Stamp   Office Number   Date

FORM CONTINUES ON OTHER SIDE

MEDICAL INSURANCE

• Include a copy of your insurance card (front and back) when you submit this form.

Nj BMM TUVEFOUT (jodmvejoh joufsobujpobm tuvefout) bsf sfrvjsfe up ibwf bddjefou boe hospitalization insurance.

Nj Qvsdibtf jotvsbodf bu ifbmuidbsf.hpw ps joufsobujpobmtuvefoujotvsbodf.dpn

Check here if you have included a copy of your insurance card.

MEDICAL HISTORY

Please check all that apply:

Anemia	Asthma	Back Problems
Depression	Diabetes	Ear Trouble
Eye Trouble	Epilepsy/Seizures	Frequent Anxiety
Hay Fever	Hepatitis	Heart Murmur
High Blood Pressure	Infectious Mononucleosis	Injury to bone/joints
Kidney Disease	Malaria	Migraine Headaches
Rheumatic Fever	Sickle Cell Disease	Stomach/Intenstinal Trouble
Thyroid Problems	Tuberculosis	

Please list any other informaton not covered above (operations, hospitalizations).