MINNESOTA STATE UNIVERSITY
moorhead

Hendrix Health Center

Hendrix Health Center is a medical clinic located on MSUM's campus for students only (by appointment)

Important Immunization Requirements:

- The attached "Immunization Record for Students Attending Post-Secondary Schools in Minnesota" form must be completed if:
  - You are exempt from completing this form if you graduated from a Minnesota high school system after the spring of 1997.
  - If you graduated from a Minnesota high school before the spring of 1997, this form must be completed.
  - All students born after 1956 and not graduated from a Minnesota high school after the spring of 1997, must complete this form.
- This form may also be submitted on-line through the following web page: http://www.mnstate.edu/hendrix/forms/index.cfm
- Please submit this form before attending MSUM. The university may prevent you from registering for classes if the immunization information is not on file in Hendrix Health Center.

Where to locate your immunization records:

1. High School Records
2. Other Colleges or Universities Attended
3. Public Health Offices
4. Physician's Records
5. Parent Records
6. Military Records

If you have questions regarding completion of the form, the immunization requirement or the services available at Hendrix Health Center, please call us at 218.477.2211

(Please keep a copy for your own records.)

MSUM Box 92 • 1104 7th Avenue South • Moorhead, Minnesota 56563
Phone: 218.477.2211 • Fax: 218.477.5867 • www.mnstate.edu
MSU Moorhead is an equal opportunity educator & employer and is a member of the Minnesota State Colleges & Universities System.

Medical History

Hendrix Health Center • MSUM
1104 9th Avenue South • Box 92
Moorhead, MN 56563

MINNESOTA STATE UNIVERSITY moorhead

Name _____

Street Address _____

City _____ State _____ Zip _____ Country _____

Phone _____ Date of Birth _____ Gender _____ Ethnicity _____

Emergency Contact Name _____ Relationship to you _____

Phone _____ Address _____

I. ALLERGIES: Medicines _____

Pollens, insect bites, stings or other _____

II. HEALTH HISTORY: Note if you have ever had any of the following. Explain any "yes" answers as needed, or provide additional records from your doctor if these _ records are needed to continue your care while at Minnesota State University Moorhead.

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Pap smear	❑	❑	Chicken Pox	❑	❑	Heart Murmur/Cardiac Problems	❑	❑	Seizures
❑	❑	Anxiety	❑	❑	Depression	❑	❑	Hepatitis (Jaundice)	❑	❑	Thyroid Disease
❑	❑	Arthritis	❑	❑	Diabetes	❑	❑	High Blood Pressure	❑	❑	TMJ Disorder
❑	❑	Asthma	❑	❑	Drug / Alcohol Problem	❑	❑	Immunosuppressive illness	❑	❑	Tuberculosis
❑	❑	Blood Disorder / Anemia	❑	❑	Drug / Alcohol Treatment	❑	❑	Migraine / Headaches	❑	❑	Major Surgery
❑	❑	Blood Transfusion	❑	❑	Antibiotics prior to dental work	❑	❑	Mononucleosis	❑	❑	Psychiatric Hospitalization
❑	❑	Cancer	❑	❑	Eating Disorder	❑	❑	Rheumatic Fever	❑	❑	Psychiatric medication

List any additional significant conditions or comments: _____

_____

Do you have any physical or psychological challenges or conditions that may impact your activity (For example: Physical Education participation or life activities)?

❑ Yes ❑ No If yes, explain _____

III. HEALTH BEHAVIORS: Respond "yes" or "no" to the following questions regarding health behaviors. Explain if necessary.

Yes	No		Yes	No	
❑	❑	Do you perform regular breast or testicular exams? How often?	❑	❑	Do you wear seat belts consistently?
❑	❑	Do you exercise? How often?	❑	❑	Do you wear a helmet when cycling?
❑	❑	Are you content with your current weight?	❑	❑	If you are sexually active, do you practice methods & precautions to prevent pregnancy & STIs, including HIV? ❑ Does not apply
❑	❑	Are you content with the way you handle stress?			
❑	❑	Do you use tobacco? How much?	❑	❑	Have you had involvement in a violent relationship?
❑	❑	Do you drink alcohol? If so, how many drinks/week?	❑	❑	Have you had any history of physical / sexual abuse?

IV. PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES:

I, _____, hereby authorize the Hendrix Health Center, their agents and consultants, to perform diagnostic and treatment procedures, which in their judgement may become necessary while at Hendrix Health Center. If I require specialized and/or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Hendrix Health Center.

Student's signature (Parent signature if student under 18): _____ Date: _____

V. NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996, I have certain rights to privacy in regards to my protected health information (PHI). By signing below, I acknowledge that I have received, read and understood the University Health Center's Notice of Privacy Practices (Privacy Notice). This notice is available on line at www.mnstate.edu/hendrix. The University Health Center reserves the right to change the terms of its Privacy Notice. If such changes are made, I understand that the Privacy Notice will be provided to me upon request.

Student's signature (Parent signature if student under 18): _____ Date: _____

*** This medical history side of the form is <u>not</u> required for admission enrollment ot MSUM.**

THIS SIDE IS REQUIRED

Immunization Record for Students Attending Post-Secondary Schools in Minnesota

Minnesota State University Moorhead

(Please complete this form and send to: Hendrix Health Center, MSUM Box 92, Moorhead, MN 56563)
Phone: 218.477.2211 Fax: 218.477.5867

Student Name (Last, FIrst, MI):	Date of Birth:	Student ID Number:

Minnesota Law (M.S. 135A.14) requires proof that all students born after 1956 are vaccinated against diphtheria, tetanus, measles, mumps, and rubella, allowing for certain specified exemptions (see below). Any non-exempt student who fails to submit the required information within 45 days after first enrollment cannot remain enrolled. This form is designed to provide the school with the information required by the law and will be available for review by the Minnesota Department of Health and the local health agency.

❑ Check here if you were born before 1957 for the age exemption. You don't have to complete the rest of this form.

Please complete only ONE part below

Part 1: Students graduating from a Minnesota high school in 1997 or later

I have previously met the MMR (measles, mumps, rubella) and Td (tetanus, diphtheria) requirements because I graduated from a Minnesota high school in 1997 or later.

Student's signature _____ Date _____

Name of high school: _____ City: _____ Date of graduation: _____

Part 2: Students who graduated from a Minnesota high school before 1997 or students from out-of-state	Mo/Day/Yr	Mo/Day/Yr
Tetanus/diphtheria (Tday) (at least one dose required within past 10 years)		
Measles/mumps/rubella (MMR) (at least one dose required at or after 12 months of age)		

I certify that the above information is a true and accurate statement of the dates on which I was vaccinated.

Student's signature _____ Date _____

Part 3: Transfer student from another Minnesota college

I am exempt from these requirements because my admission records indicate I have met the requirements as an enrolled student in another post-secondary school in Minnesota.

Student's signature _____ Date _____

Name of previous Minnesota college: _____ Dates of enrollment: from _____ to _____

Part 4: Other exemption(s)

Medical Exemption: The student named above lacks one or more of the required immunizations because he/she: *(Check all that apply and fill in the appropriate blanks)*

❑ has a medical problem that precludes the _____ vaccine

❑ has not been immunized because of a history of _____ disease

❑ has laboratory evidence of immunity against _____ disease

Physician's signature _____ Date _____

Conscientious Exemption: I hereby certify by notarization that immunization against _____ disease is contrary to my conscientiously held beliefs.

Student's signature _____ Date _____

Subscribed and sworn to before me this _____ day of _____ , 20 _____ .

Signature of notary _____