Olivet Nazarene University Health and Immunization Form

Please Print or Type

Student's Name: _____ ONU I.D. # _____ Term First Attending: Fall ☐ Spring ☐ Year _____
LAST FIRST MIDDLE

Address: _____ Birthdate: _____ Sex: M ☐ F ☐
STREET CITY STATE ZIP MO. DAY YR.

Telephone: (_____) _____ - _____ SS#: _____ ONU Intercollegiate Sports: _____

PART I. MEDICAL HISTORY

To be completed by the student. Please check any of the following you have had or now have:

- ☐ Acne
- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Back problems
- ☐ Bladder infections
- ☐ Bleeding disorder
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chest pain
- ☐ Chicken pox
- ☐ Chronic cough
- ☐ Colds
- ☐ Concussion
- ☐ Crying spells
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug addiction
- ☐ Earaches
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Eye problems
- ☐ Fainting
- ☐ Frequent headaches
- ☐ Frequent indigestion
- ☐ Frequent sore throats
- ☐ Hearing loss
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ Hepatitis B
- ☐ Hernia
- ☐ Hypertension
- ☐ Insomnia
- ☐ Jaundice
- ☐ Joint pain
- ☐ Kidney disease
- ☐ Measles (German) (Rubella)
- ☐ Measles (Rubeola)
- ☐ Mumps
- ☐ Mono
- ☐ Nervous exhaustion
- ☐ Night sweats
- ☐ Painful urination
- ☐ Pneumonia
- ☐ Polio
- ☐ Rectal bleeding
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ TB
- ☐ Ulcers
- ☐ Venereal disease
- ☐ Whooping cough

Drug Allergies _____

Injuries/Accidents _____

Surgery (Operations) _____

Permanent disability (type) _____

Routine medications (list) _____

_____
STUDENT'S SIGNATURE

_____
DATE

PART II. IMMUNIZATION *(Please see reverse side for immunization rules.)*

Please provide the month, day and year for every dose administered. The day and month is required if you cannot determine if the vaccine was given prior to the minimum interval or age.

REQUIRED IMMUNIZATIONS	1 MO	1 DAY	1 YR	2 MO	2 DAY	2 YR	3 MO	3 DAY	3 YR	4 MO	4 DAY	4 YR	5 MO	5 DAY	5 YR
DPT (Diphtheria/Pertussis/Tetanus)															
DT, TD (Diphtheria/Tetanus), **TDAP or ADACEL** (Tetanus/Diphtheria/Pertusis) ***Booster req'd every 10 yrs.***															
COMBINED MMR (Measles/Mumps/Rubella) **2 doses required 28 days apart, beginning on or after first birthday.**															
COMBINED MR (Measles/Rubella)															
RUBEOLA (disease date or titer date)										(For titers, a copy of lab results MUST be attached.)					
RUBELLA (titer date — disease date not acceptable															
MUMPS (disease date or titer date)															

RECOMMENDED IMMUNIZATIONS	1 MO	1 DAY	1 YR	2 MO	2 DAY	2 YR	3 MO	3 DAY	3 YR	4 MO	4 DAY	4 YR	5 MO	5 DAY	5 YR
HBV (Hepatitis B)															
MENINGOCOCCAL (Meningitis)															
POLIO Vaccine															
VARICELLA (Chicken Pox) (or disease date)															
HPV (Gardasil)															
TB Skin Test															

HEALTH PROVIDER SIGNATURE (physician, RN, PA, school nurse or school health official) verifying immunizations:

_____ _____
SIGNATURE DATE

_____ _____
SIGNATURE DATE

PART III. PHYSICAL EXAMINATION *(To be completed by physician, nurse practitioner or physician's assistant)*

EVALUATION: (Required within 12 months of enrollment)

	NORMAL	ABNORMAL	FOLLOW-UP — COMMENT
Height _____ Weight _____			
Heart Rate _____			
Blood Pressure _____			
Skin			
Eyes			
Ears			
Nose			
Throat			
Throat/Dental			
Cardiovascular			
Respiratory			
Gastrointestinal			
Genito-Urinary			
Neurological			
Muscular Skeletal			
Scoliosis Screening			
Nutritional Status			

Other _____

ON THE BASIS OF THIS EXAMINATION ON THIS DAY, I APPROVE THIS STUDENT'S PARTICIPATION IN:

Interscholastic Sports (for 1 yr.) . . . ☐ YES . . .Type of sport _____ . . . ☐ NO

Physical Education . . . . . ☐ YES . . . . . ☐ NO

IF NO, PLEASE ATTACH EXPLANATION.

Physician's Name (Print) _____

Physician's Signature _____

Address _____

Telephone _____ Date _____

PLEASE SEND TO HEALTH SERVICES OR FAX TO 815-935-4997.

Immunization Rules—Please read carefully!

The Illinois College Student Immunization Act (110-ILCS 20) states: All students born on or after January 1, 1957, and **ENROLLED IN 6 OR MORE HOURS OF ON-CAMPUS CLASSES** must submit proof of immunity for diphtheria/tetanus, measles, mumps and rubella. Compliant immunization records for new students must be received by the office of Counseling & Health Services by **August 1** for new students enrolling in the Fall Semester and **December 15** for new students enrolling in the Spring Semester.

Students not in compliance with Illinois' immunization law 30 days after the first day of classes will receive a $25 non-compliance charge to their student accounts. Students who remain in non-compliance will have a hold placed on their University records and will be unable to register for future semesters at Olivet Nazarene University.

HOW TO COMPLETE THIS FORM:

1. **Part I** must be completed and signed by the student.
2. **PART II** must be signed by either your doctor, a registered nurse or other public health official and may be completed by attaching one of the following:
   A. A copy of the student's health records from high school.
   B. Comparable documentation from prior college or university.
   C. Verification of immunization taken from your doctor's records, military records or other health care provider such as a Public Health Department.

   SPECIFIC REQUIREMENTS:
   Td—Booster required within the last 10 years. TETANUS TOXOID IS NOT ACCEPTABLE.
   MEASLES* (Rubeola)—Must show proof of TWO doses after 12 months of age.
   RUBELLA* (German Measles)—One dose required after 12 months of age.
   MUMPS*—One dose required after 12 months of age.
   *Two doses of MMR vaccine eliminate the need for separate measles, mumps and rubella doses.
   International students must submit proof of three DTs and two MMRs.

3. **PART III** must be completed and signed by your physician within 12 months prior to enrollment.
4. All dates must include MONTH, DAY and YEAR.
5. All laboratory evidence of immunity must be accompanied by a copy of the lab report.
6. History of disease is NOT acceptable as proof of immunity for RUBELLA.
7. All live vaccines must have been given after 1969, ON OR AFTER 12 MONTHS OF AGE.

Incoming Intercollegiate Athletes: *Copies of your physical exam **must be sent to Counseling & Health Services** in addition to your coach or athletic office.*

Please save a copy of your health forms for your records.

MAIL OR FAX HEALTH FORMS TO:

Counseling & Health Services
Olivet Nazarene University
One University Avenue, Box 6032
Bourbonnais, IL 60914

FAX: 815-935-4997

PHONE: 815-939-5256