Florida Agricultural and Mechanical University
Student Health Services
116 Foote-Hilyer Administrative Center
Tallahassee, FL 32307
Phone: 850-599-3777 Fax:850-412-5643

Health History Form

To Be Completed by Student

Last Name First Name M.I. SSN

Permanent Address City State Zip Area Code/Phone #

Date of Birth (mo/day/yr) _____ Gender: ☐ M ☐ F ☐ T Email_____

CLASS YOU ARE ENTERING:
FR SO JR SR Grad Prof

PREVIOUSLY ENROLLED AT FAMU?
___Y ___N If yes, when?_____

SEMESTER ENTERING
Fall Spring Summer Year_____

Name of emergency contact Relationship Home/cell # Work #

Family Health History

Has any person, related by blood, had any of the following:

	Yes	No	Relationship
Alcohol/drug problem			
Allergy			
Asthma			
Blood or clotting disorder			
Cancer (type)			
Convulsions			

	Yes	No	Relationship
Cholesterol or blood fat disorder			
Diabetes			
Glaucoma			
Heart attack before age 55			
High Blood Pressure			

	Yes	No	Relationship
Obesity			
Psychiatric illness			
Stroke			
Suicide			
Tuberculosis			
Other_____			

Personal Health History

Do you have allergies? ____Yes ___No Are you receiving allergy injections? ____Yes ___No Please specify allergy:
___Aspirin ___Sulfa drugs ___ Penicillin ___Insect sting ___ Food allergy (which?) ___ Other drugs (list)_____

Have you had or do you have now any of the following? Please indicate Y (yes) or N (no) and the year of first occurrence.

	Y	N	Year		Y	N	Year		Y	N	Year		Y	N	Year
Abdominal pain (severe/recurrent)				Chronic cough				Hepatitis				Rheumatic fever			
Alcohol/Drug Use				Concussion				High blood pressure				Serious skin disease			
Anemia or Sickle Cell Anemia or Trait				Depression				Insomnia				Seizures/ convulsions			
Anorexia/Bulimia				Diabetes				Intestinal Problems				Sinusitis			
Anxiety				Dizziness or fainting				Irregular menses				STDs			
Asthma				Ear-chronic infection				Kidney stone or kidney disease				Major Surgeries			
Arthritis				Emotional Problems				Lupus/Other Autoimmune				Thyroid trouble			
Back/Neck Injury				Eye problem				Malaria				Tuberculosis			
Bladder or kidney infection				Fatigue				Mononucleosis				Testicles-problems			
Blood transfusion				Headaches				Menstrual cramps-severe				Tobacco Use			
Bone, joint problem, fracture or deformity				Head injury (severe)				Physical disability				Vomiting-frequent			
Breathing problems				Hearing loss				Pain-chronic				Current	Height		Weight
Cancer or Tumor				Heart disease or murmur				Pneumonia				Other (specify)			
Chest pain				Hernia (specify)				Rectal disease							

Print Name _____
Last First

FLORIDA A&M UNIVERSITY IMMUNIZATION RECORD

All students born after 1/1/1957 must provide proof of two (2) MMR (measles, mumps, rubella) immunizations. The first MMR must have been given on or after the first birthday. The second MMR must be given 28 days or more after the first one. Positive titers for Measles (Rubeola), German Measles (Rubella), and Mumps antibodies are acceptable if documented by completed lab results showing positive titers. Students born prior to 1/1/1957 need only to complete the Health History on the other side of this form **and** Part 2 below. This form must be received in our office prior to registration. Call 850-599-3779 if you have questions.

PART 1: REQUIRED – *THIS SECTION MUST BE COMPLETED BY MEDICAL OR AUTHORIZED PERSONNEL ONLY*

In order to be considered official, this section must contain a signature of authorizing person AND an office stamp. Copies of official records may be attached and must include the student's name on front cover of all documents. *Any changes, additions, write-overs, use of different ink/handwriting or use of white-out must be re-signed by the authorizing person providing proof.* We reserve the right to interpret the validity of all documents.

REQUIRED IMMUNIZATIONS

MMR Immunizations
1st MMR _____/_____/_____
2nd MMR _____/_____/_____

OR

Positive Titer (must be accompanied by lab results)
Rubella: _____/_____/_____ ***and***
Rubeola: _____/_____/_____ ***and***
Mumps: _____/_____/_____

Students must have immunizations for meningococcal meningitis and hepatitis B vaccine OR complete the waiver for each below in Part 2.

Meningococcal meningitis _____/_____/_____
Meningitis booster dose _____/_____/_____
Meningitis B _____/_____/_____

Hepatitis B Dose 1: _____/_____/_____
Dose 2: _____/_____/_____
Dose 3: _____/_____/_____

RECOMMENDED FOR ALL STUDENTS, BUT NOT REQUIRED

Td or Tdap (latest booster) _____/_____/_____
Chicken Pox (varicella)#1 _____/_____/_____
#2 _____/_____/_____
Hepatitis A dose 1: _____/_____/_____
dose 2: _____/_____/_____
HPV dose 1:_____ dose 2: _____ dose 3:_____

Polio (most recent dates) _____/_____/_____
TB skin test (PPD) _____/_____/_____
mm _____ Pos _____ Neg _____
TB treatment dates:
Prophylactic INH ____/____/____ to ____/____/____
Therapeutic treatment ____/____/____ to ____/____/____

The signature verifies all shots documented above – please mark out any blank spaces. Shots given after the form has been signed must be documented on an enclosed separate sheet of paper with new signature, date and office stamp.

PHYSICIAN OR AUTHORIZED SIGNATURE (MANDATORY) OFFICE STAMP (Address/Phone/Fax # MANDATORY)

PART 2: TO BE COMPLETED BY ALL STUDENTS

I have read and understand the immunization requirements on this form. I have received the required information regarding the risks of acquiring meningococcal meningitis and hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or actively decline these immunizations.

☐ I decline receiving the meningococcal meningitis vaccine.

☐ I decline receiving the hepatitis B vaccine.

I HAVE READ AND UNDERSTAND THE IMMUNIZATION REQUIREMENTS ON THIS FORM. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at FAMU Student Health Services and for registration here.

Student's Signature | Last 4 digits of SSN | Date of Birth | Today's Date

REQUIRED AUTHORIZATION FOR CARE OF STUDENTS UNDER AGE 18: I concur with the above and authorize, at the discretion of health services personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but failure to make contact will not prevent emergency treatment if necessary to help preserve life or health.

Signature of Parent or Guardian Date

MAIL OR FAX COMPLETED FORMS TO 850-599-3067