To the Student:
You have been accepted. Information you provide will not be used to influence your situation at the College; it will be used, if necessary, solely as an aid to providing necessary health care while you are a student.

College of Saint Benedict
Health Services
37 South College Ave.
St. Joseph, MN 56374
Fax: 320-363-6396

Must be Completed and Returned by June 15th for Fall admission or February 1st for Spring admission.

Mail, fax, or email to tlongfellow@csbsju.edu

CSB Health Form

CONFIDENTIAL (TO BE COMPLETED BY STUDENT)

Name (Print) _____
Last First Middle

Home Address: _____ City: _____ State: _____ Zip: _____

Student Cell Phone #: _____ Home phone #: _____ Birth Date: _____

Sex: M ☐ F ☐ Sex Identity: M ☐ F ☐

Reminder: Please carry a copy of your health insurance identification card with you on campus.

FAMILY HISTORY

If any blood relative has a history of any of the following, please indicate and note age of death if applicable:

Illness	Relationship	Age of death	Illness	Relationship	Age of death
☐ High Blood Pressure			☐ Arthritis		
☐ Stroke			☐ Stomach Disease		
☐ Cancer			☐ Asthma		
☐ Diabetes			☐ Tuberculosis		
☐ Thyroid Disease			☐ Mental Illness		
☐ Anemia			☐ Epilepsy		
☐ Kidney Disease			☐ Other		

Please list number of brothers and sisters with their ages: _____

PAST MEDICAL HISTORY

Allergies: (Medications, foods, insects, latex, environmental)

MEDICATIONS TAKEN REGULARLY: (Include: prescription and nonprescription drugs)

SURGERIES/ACCIDENTS/HOSPITALIZATIONS:

MEDICAL HISTORY

Check if you have had any of the following symptoms or diseases. Comment below.

- ☐ Scarlet or Rheumatic Fever
- ☐ Measles
- ☐ German Measles (Rubella)
- ☐ Mumps
- ☐ Malaria
- ☐ Mononucleosis
- ☐ Sinusitis
- ☐ Vision problems
- ☐ Ear, Nose, Throat trouble
- ☐ Pneumonia
- ☐ Asthma
- ☐ Chronic cough
- ☐ Acne
- ☐ Other skin problems
- ☐ Headaches
- ☐ Sleep problems
- ☐ Anxiety
- ☐ Phobias
- ☐ Depression
- ☐ Worry or Nervousness
- ☐ Suicidal thoughts
- ☐ Other Mental Health Concerns
- ☐ Head injury
- ☐ Convulsions
- ☐ Pain/pressure in chest
- ☐ Palpitations (Heart)
- ☐ High or Low Blood Pressure
- ☐ Heart Murmur
- ☐ Chronic fatigue
- ☐ Thyroid disease
- ☐ Disease or injury of joints
- ☐ Back problems
- ☐ Tumor/Cyst
- ☐ Cancer
- ☐ Jaundice/Liver trouble
- ☐ Stomach/Intestinal trouble
- ☐ Recurrent Diarrhea
- ☐ Anemia
- ☐ Recent weight gain/loss
- ☐ Dizziness/Fainting
- ☐ Eating Disorder
- ☐ Frequent urine infections
- ☐ Diabetes
- ☐ Tattoos
- ☐ Sexually Transmitted Diseases
- ☐ History of Alcohol/Drug Addiction

Social History

Cigarette use ☐ Yes ☐ No

Pk/Day _____

Alcohol use ☐ Yes ☐ No

Drinks/week _____

Street drug use ☐ Yes ☐ No

Menstrual History

- ☐ Irregular periods
- ☐ Severe cramps
- ☐ Excessive flow

IMMUNIZATION RECORD

Required to be completed by health care provider or attach clinic immunization record. Return to Health Services before June 15th or February 1st.

Name: _____ Birth date: _____/_____/_____
Last First Middle Month Day Year

REQUIRED IMMUNIZATIONS

Minnesota law requires proof of immunization against Measles, Mumps, Rubella, Tetanus and Diphtheria.

MMR (Measles, Mumps, Rubella) Dose #1 given at age 12 months or later. Dose #2 given at least 28 days after first dose.
Two doses required prior to entrance. #1 _____/_____/_____ #2 _____/_____/_____
Month Day Year Month Day Year

Tetanus/Diphtheria
Primary series of 4 doses DPT
#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ #4 _____/_____/_____
Mo. Day Year Mo. Day Year Mo. Day Year Mo. Day Year

TD/Tdap (Tetanus-Diphtheria Booster) One dose required with the **last 10 years.** #1. _____/_____/_____ ☐ Td or ☐ Tdap?
Month Day Year

OTHER IMMUNIZATIONS

Polio 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____ 4. _____/_____/_____
Month Day Year Month Day Year Month Day Year Month Day Year

Meningitis 1. _____/_____/_____ ☐ Menomune or ☐ Menactra?
Month Day Year

Hepatitis A 1. _____/_____/_____ 2. _____/_____/_____
Month Day Year Month Day Year

Hepatitis B 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____
Month Day Year Month Day Year Month Day Year

HPV 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____
Month Day Year Month Day Year Month Day Year

Varicella Have you had chicken pox? ☐ Yes ☐ No

If no, please indicate date of vaccinations.
1. _____/_____/_____ 2. _____/_____/_____
Month Day Year Month Day Year

History of reaction to immunizations: ☐ Yes ☐ No Which immunizations?_____ Type of Reaction: _____

Signature of Medical Professional_____ Date _____

CONSCIENTIOUS / RELIGIOUS EXEMPTION

Must fill out if unable to meet required immunizations due to conscientious or religious belief.

MUST BE NOTARIZED

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations.

_____ _____
Student Signature (or parent or legal guardian if under 18 years of age) Date

Subscribed and sworn to me on the _____ day of _____, 20_____.

_____
Signature of Notary

MEDICAL EXEMPTION

MUST BE COMPLETED IF UNABLE TO MEET REQUIRED IMMUNIZATIONS DUE TO MEDICAL CONTRAINDICATIONS.
The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

_____ _____
Signature of Medical Professional *Date*

COLLEGE OF
Saint Benedict

FOR INTERNATIONAL STUDENTS ONLY

Student Name (required)

Student Name: _____

Birth Date: _____

Tuberculosis Screening Form

The College of Saint Benedict requires that you have a screening tuberculosis test completed prior to the start of the semester if you are a student entering the United States from a foreign country.

Please print this document and have your health care provider complete and sign it.

Health Care provider: Either an IRGA or tuberculin skin test (TST) is required.

IGRA Results: _____ Negative _____ Positive
Tuberculin Skin Test: Date given _____ Date Read: _____
Results: _____ (record actual mm of induration; if no induration, write "0").
Interpretation (based on mm of induration as well as risk factors) _____ Positive _____ Negative
Chest x-ray (required if TST or IGRA is positive) results: ____ Normal _____ Abnormal
Date of chest x-ray: _____
Patient is considered free of active tuberculosis: _____ yes _____ no

HEALTH CARE PROVIDER SIGNATURE (required)

Health Care Provider Signature: _____

Print Name: _____Date:_____

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