Northeast community college

Student Health

Date of First Semester Enrollment:
Year _____ (check beginning semester)
❒ Fall (August – December)
❒ Spring (January – May)
❒ Summer (May – July)

Confidential Health Information

Please print

Name _____
Last First Middle Previous Last Name

Date of Birth _____ Sex: ❒ Male ❒ Female Social Security Number _____ - _____ - _____

Address _____ City _____ State _____ Zip _____

Person(s) to be notified in emergency

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Telephone (_____) _____ Work Telephone (_____) _____

Family Physician

Name _____

Address _____ City _____ State _____ Zip _____

Telephone (_____) _____

Medical Insurance Company _____ Policy No. _____

Childhood Diseases: (Please check Yes or No)

Have You Had	Yes	No	Have You Had	Yes	No
a. Chickenpox			d. Measles (German)		
b. Diphtheria			e. Mumps		
c. Measles (Red)			f. Scarlet Fever		

Medication (List any medication taken regularly)

_____

_____

Allergies

Medications ❒ Yes ❒ No (List) _____
Others ❒ Yes ❒ No (List) _____

Immunizations – See cover letter for brief explanation

A. Tetanus – Diphtheria
- ❒ Completed primary series of tetanus-diphtheria immunizations (four doses with DTaP or DTP)
  Month: _____ Year: _____
- ❒ Last tetanus-diphtheria booster (Recommended dose is every 10 years)
  Month: _____ Year: _____

B. Hepatitis B (series of three)
Month: _____ Year: _____
Month: _____ Year: _____
Month: _____ Year: _____

C. M.M.R. (Measles, Mumps, Rubella)
- ❒ Dose 1 – given at age 12-15 months or later
  Month: _____ Year: _____
- ❒ Dose 2 – given at age 4-6 years or later, and at least one month after first dose
  Month: _____ Year: _____

D. Polio
Month: _____ Year: _____
Completed

E. Meningitis
Month: _____ Year: _____

F. Tuberculosis Screening
Month: _____ Year: _____

Personal Health History (Please check Yes or No)

Have You Had	Yes	No	2. Acute Diseases:	Yes	No
1. Chronic Diseases:			a. Rheumatic Fever		
a. Arthritis			b. Infectious Mononucleosis		
b. Asthma			c. Hepatitis		
c. Bronchitis			d. Poliomyelitis		
d. Cancer			e. Tonsillitis		
e. Convulsions/Seizures			f. Venereal Disease		
f. Colon Diseases			g. Typhoid Fever		
g. Deaf/Hearing Loss			h. Other		
h. Depression (Prolonged)			3. Have you had any surgical operations (e.g., appendectomy, tonsillectomy, hernia)?		
i. Diabetes					
j. Eating Disorder			4. Have you ever been hospitalized? Specify, including date(s).		
k. Epilepsy					
l. Emotional/Behavioral Problems			5. Do you wear glasses or contact lenses regularly?		
m. Emphysema					
n. Gallbladder/Liver Disease			6. Are you now under the care of State Rehabilitation?		
o. Hayfever					
p. Headaches/Migraines			7. Have you been advised to seek and/or received psychiatric or psychological help?		
q. High Blood Pressure					
r. Heart Disease			8. Do you have any physical or emotional conditions which might make it inadvisable for you to participate in physical education or to carry a full study load?		
s. Kidney Disease					
t. Malaria					
u. Orthopedic Problems					
v. Speech Problems			This health information is optional and requested for the purpose of reporting to federal compliance agencies only and will not be used in determining admission status.		
w. Thyroid					
x. Tuberculosis					
y. Ulcer					
z. Other					

If you checked yes to any of the above questions 1-8, use space below to provide additional information.

_____

_____

_____

_____

This information is given in confidence for the sole use of the NECC Student Health Office. I certify the above history is complete and accurate to the best of my knowledge.

Signature of Student _____ Date _____

CONSENT TO BE SIGNED BY PARENT OR GUARDIAN IF STUDENT IS UNDER 19 YEARS OF AGE:

In the event of emergency, illness, or injury, permission is hereby granted to the staff of the Student Health Office at Northeast Community College to refer the above-named student to a local physician and/or health care facility. Further permission is granted to allow the student to undergo any treatment that is deemed necessary by the said attending physician.

Signature of Parent or Guardian _____

Mail this form to: Student Health Advisor, Northeast Community College, P.O. Box 469, Norfolk, NE 68702-0469

Date	Northeast Community College Student Health Office Notes