



## COE COLLEGE ENGLISH AS A SECOND LANGUAGE PROGRAM Medical History and Immunization Record

Welcome to Coe College! The Medical History form is to be completed by you. If you have a chronic illness, health problem or handicap, you should provide information from your doctor. All of the information given to Health Services is confidential and will not be released to anyone else without your knowledge and consent.

### Part I: Personal Information

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Home address \_\_\_\_\_  
\_\_\_\_\_

Home telephone number \_\_\_\_\_ FAX \_\_\_\_\_ E-mail address \_\_\_\_\_

Parent's names \_\_\_\_\_

Parents' Telephone, FAX, and/or E-mail address \_\_\_\_\_

Name of health insurance company \_\_\_\_\_

### Part II: Personal Health History

Please circle "yes" or "no." If your answer is "yes," please explain with details on the back of this page. Your information will be kept private; it is only for the Coe College nurse.

Have you ever had...	Yes	No	Have you ever had...	Yes	No	Have you ever had...	Yes	No
Eye trouble?			Mumps?			Surgery?		
Ear, nose, or throat trouble?			Chicken Pox?			Head injury?		
Food allergy?			Rhumatic Fever?			Hernia with rupture?		
Drug allergy?			Hepatitis?			Eating disorder?		
Environmental allergy?			Gallbladder problems?			Depression?		
Hay fever?			Diabetes?			Anxiety?		
Asthma?			Tuberculosis?			Insomnia?		
Stomach/intestinal problems?			Tumor or cancer?			HIV?		
Urinary problems?			High blood pressure?			Sexually Transmitted Diseases?		

On the back of this sheet, please comment on any health concerns you have. Include (1) activity restrictions, (2) medical or mental health services you are using now, (3) serious illnesses or hospitalizations within the last 5 years, (4) chronic or recurring health problems, and (5) any regular medications and treatment you are currently taking.

Sign your name to the following :

**I authorize the Advanced Registered Nurse Practitioner to treat me in the case of medical need while I am a student at Coe College.**

Student signature \_\_\_\_\_ Date \_\_\_\_\_

(Please return to: Barbara Drexler, E.S.L. Director, Coe College, 1220 First Avenue N.E., Cedar Rapids, Iowa 52402)

**Part III: Physical Examination and Immunization history**

To: Parents and Incoming International students: Coe College requires a physical examination and current immunizations on file in order for students to register for classes.

**Physical Examination  
(To be completed by your healthcare provider)**

Student's name \_\_\_\_\_ Birthdate \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Heart rate/pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Vision: R 20/\_\_\_\_\_ L 20/\_\_\_\_\_ Corrected: Yes \_\_\_\_\_ No \_\_\_\_\_ Pupils: Equal \_\_\_\_\_ Unequal \_\_\_\_\_

Hearing: R \_\_\_\_\_ L \_\_\_\_\_ Dental care needed: Yes \_\_\_\_\_ No \_\_\_\_\_ Hgb/Hct \_\_\_\_\_

UA (Urine analysis) \_\_\_\_\_ Urine Protein: \_\_\_\_\_ Urine sugar \_\_\_\_\_

	Normal	Abnormal	Describe if abnormal
Eyes/Ears/Nose/Throat			
Respiratory			
Cardiovascular			
Gastrointestinal/Abdomen			
Genitourinary/Genitalia/Hernia			
Endocrine/Metabolic			
Neuropsychiatric			
Eating Disorder			
Skin			
Musculoskeletal			
Menstrual cycle (Women)			

Is the student in good health? \_\_\_\_\_ Are there restrictions on activity? \_\_\_\_\_

How long have you known the patient? \_\_\_\_\_

List any current medications, health problems, or treatment (in English).

Signature of Healthcare Provider \_\_\_\_\_ Date \_\_\_\_\_

## IMMUNIZATION HISTORY

In addition to the questions on the first page, the Coe College nurse needs the following information about every college student's immunization history. These immunizations are required in the United States. We apologize for asking so many questions. Some of these diseases are not so serious in children, but in adults, they may be very serious. That is why American colleges are so careful about collecting this information.

Please ask your parents and/or your doctor, clinic, or hospital for this information.

**1. This immunization is required in the U.S.: Diphtheria Pertussis Tetanus (DPT)**

a. Dates of original series: \_\_\_\_\_

b. Booster dates: \_\_\_\_\_

**2. This immunization is also required: Polio**

a. Dates of original series: \_\_\_\_\_

b. Booster dates: \_\_\_\_\_

**3. Chicken Pox:** Date of Disease \_\_\_\_\_  
 Date of Varicella Vaccination (if student did not have chicken pox) \_\_\_\_\_

4. Please give information about the dates of your first immunization and booster for each of these diseases. If you had the disease itself, please tell when.

Disease	Date of original immunization	Date of booster	Did you contract the disease? If so, give the date.
Measles (Rubeola) **			
Mumps			
Rubella			

<p><b>**It is required that the students have one MMR and a 2<sup>nd</sup> Measles (Rubeola) booster or 2<sup>nd</sup> MMR.</b></p>
---

**4. Test for tuberculosis: (REQUIRED)**

a. Date of most recent tuberculin test (Mantoux)? \_\_\_\_\_

b. Results: negative \_\_\_\_\_; positive \_\_\_\_\_

<p><b>If the results of the TB test are positive, a chest X-ray is required.</b></p>
--

Please return this form to:

Barbara J. Drexler, E.S.L. Director, Coe College  
 1220 First Avenue N.E., Cedar Rapids, Iowa 52402 U.S.A.