CSB/SJU HEALTH FORM

DUE DATE: June 15 if starting classes in August, or February 1 if starting in January.

College of Saint Benedict / Saint John's University

MAIL: **CSB/SJU HEALTH SERVICES**
RE: Health Form
37 South College Avenue
St. Joseph, MN 56374

FAX: (320) 363-6396

FORM: www.csbsju.edu/health-services/csbsju-health-form

QUESTIONS: Contact Health Services @ healthform@csbsju.edu
Messages are checked intermittently and will be returned within 5 business days.

You have been accepted to CSB/SJU. This form should be completed by the CSB/SJU enrolled student. Information you provide will not be used to influence your situation while in college. It will be used, if necessary, solely as an aid to providing necessary health care.

CONFIDENTIAL INFORMATION

Name *(Print Legibly)* _____ **Birth Date** _____
Last First Middle Month Day Year

Home Address _____ **City** _____ **State** _____ **Zip** _____

Student Cell Phone # _____ **Home Phone #** _____

Emergency Contact _____ **Relationship** _____ **Phone #** _____ **Deferred** ☐

Gender: ☐ Female ☐ Male ☐ Questioning ☐ Transgender ☐ Nonbinary ☐ Other **Reminder:** Please carry a copy of your health insurance identification cards 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.

- ☐ 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
- ☐ 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
- ☐ Headaches

Menstrual History

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

Social History

Cigarette use ☐ Yes ☐ No
Pk/Day
Alcohol use ☐ Yes ☐ No
Drinks/week _____
Street drug use ☐ Yes ☐ No

Additional Comments: _____

CSB/SJU IMMUNIZATION RECORD

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

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. _____/_____/_____
Month Day Year *Month Day Year* *Month Day Year* *Month Day Year*

TD/Tdap (Tetanus-Diphtheria Booster)
One dose required with the **last 10 years.**

1. _____/_____/_____ ☐ Td ☐ Tdap
Month Day Year

OTHER IMMUNIZATIONS

COVID-19 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____ (Booster)
Month Day Year Month Day Year 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

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

Polio 1. _____/_____/_____ 2. _____/_____/_____ 3. _____/_____/_____ 4. _____/_____/_____
Month Day Year 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 immunization requirements for Measles, Mumps, Rubella, Tetanus and Diphtheria due to conscientious or religious belief.

I hereby certify by notarization that my conscientious or religious belief is opposed to immunizations. **Document MUST be notarized.**

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

Subscribed and sworn to me on the _____day of _____, 20_____

Signature of Notary: _____

MEDICAL EXEMPTION

Must fill out if unable to meet immunization requirements for Measles, Mumps, Rubella, Tetanus and Diphtheria due to medical reason.

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: _____

FOR INTERNATIONAL STUDENTS ONLY

COLLEGE OF
Saint Benedict

Saint John's
UNIVERSITY

Name ***(Print Legibly)*** _____ **Birth Date**_____
Last *First* *Middle* *Month* *Day* *Year*

Banner ID #_____

TUBERCULOSIS SCREENING TEST

If you are a student entering the United States from a foreign country, the College of Saint Benedict and Saint John's University require that you complete a tuberculosis screening test within six (6) months of the start of the semester.

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.

SOCIAL HISTORY

IGRA Results ---------- ☐ Positive ☐ Negative

Tuberculin Skin Test ---------- Date Given: _____/_____/_____ (Month Day Year) Date Read: _____/_____/_____ (Month Day Year)

Tuberculin Skin Test Results ----------
Record actual mm of induration; if no induration, write "0"
Induration: _____

Interpretation ----------
Based on mm of induration as well as risk factors
☐ Positive ☐ Negative

Chest X-Ray Results----------
Required if TST or IGRA is positive
☐ Normal ☐ Abnormal Date of Chest X-Ray: _____/_____/_____ (Month Day Year)

Patient is considered free of active tuberculosis -- ☐ Yes ☐ No

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HEALTH CARE PROVIDER SIGNATURE (required)

Health Care Provider Signature: _____

Print Name: _____ Date _____

FOR MINOR AGED STUDENTS ONLY

MINOR CONSENT TO MEDICAL TREATMENT

Students under the age of 18 at the time of enrollment cannot be treated for health-related services without consent. Exceptions to this are governed by Minnesota Statutes, Chapter 144. Exceptions are summarized below, and all other treatment requires parental/guardian consent. In signing below, I give CSB/SJU Health Services permission to treat my child while they are a registered student at CSB/SJU.
I may revoke this consent at any time with written notice to CSB/SJU Health Services.

SITUATIONS WHERE PARENTAL CONSENT IS NOT NECESSARY WHEN TREATING MINORS

144.341 Living apart from parents and managing financial affairs, consent for self.
Notwithstanding any other provision of law, any minor who is living separate and apart from parent(s) or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing personal financial affairs, regardless of the source or extent of the minor's income, may give effective consent to personal medical, dental, mental, and other health services, and the consent of no other person is required.

144.342 Marriage or giving birth, consent for health service for self of child.
Any minor who has been married or has borne a child may give effective consent of personal medical, mental dental and other health services, or to services for the minor's child, and the consent of no other person is required.

144.343 Pregnancy, venereal disease, alcohol or drug abuse, abortion.
Associated any minor may give effective consent for medical, mental, and other health services to determine the presence of or to treat pregnancy and conditions therewith, venereal disease, alcohol and other drug abuse, and the consent of no other person is required.

144.344 Emergency Treatment.
Medical, dental, mental, and other health services may be rendered to minors of any age without the consent of a parent or legal guardian when, in the professional's judgment, the risk to the minor's life or health is of such a nature that treatment should be given without delay and the requirement of consent would result in delay or denial of treatment.

144.3441 Hepatitis B vaccination.
A minor may give effective consent for a hepatitis B vaccination. The consent of no other person is required.

144.345 Representations to persons rendering services.
The consent of a minor who claims to be able to give effective consent for the purpose of receiving medical, dental, mental, or other health services but who may not in fact do so, shall be deemed effective without the consent of the minor's parent or legal guardian, if the person rendering the service relied in good faith upon the representations of the minor.

144.346 Information to parents.
The professional may inform the parent or legal guardian of the minor patient of any treatment given or needed where, in the judgment of the professional, failure to inform the parent or guardian would seriously jeopardize the health of the minor patient.

144.347 Financial responsibility.
A minor so consenting for such health services shall thereby assume financial responsibility for the cost of said services

Parental / Legal Guardian Consent:
I give CSB/SJU Health Services permission to treat:

Minor Child's Full Name _____ Date of Birth_____
Print Legibly

My signature indicates that I am the legal parent or guardian of the above-named minor and that I am allowing my child to be treated at CSB/SJU Health Services in the event of an accident, injury, illness, or other medical condition. I understand that I am responsible for all costs incurred and that an insurance ready bill will be provided for me to submit to my insurance company. I recognize that I have the right to revoke this consent and that this consent is not needed when the above-named student reaches the age of 18 or meets any of the conditions identified above.

Parent/Guardian Full Name _____
Print Legibly

Parent/Guardian Signature_____ Date_____