Return completed forms to:
Broadlawns Community Clinic at Drake
2970 University Ave. Des Moines, IA 50311
Phone: 515-216-5100
Fax: 515-216-5199
Email: drakecommunityclinic@broadlawns.org

Drake University Medical History Form

7KH 'UDNH 8QLYHUVLW\ 6WXGHQW +HDOWK &HQWHU UHTXHVWV WKLV FRQ¿GHQWLDO L
SXUSRVH RI SURYLGLQJ SDWLHQW FDUH 3HUVRQV RXWVLGH WKH VWXGHQW KHDO

7R KHOS XV EHWWHU VHUYH \RX SOHDVH SURYLGH D FRS\ RI \RXU LQVXUDQFH FD

3OHDVH SURYLGH D FRPSOHWHG KHDOWK IRUP LPPXQL]DWLRQ GRFXPHQWV GLUHFWO\ WR WKH 6WXGH
FRPSOHWHG KHDOWK IRUP LPPXQL]DWLRQ GRFXPHQWV GLUHFWO\ WR WKH 6WXGHQW
3OHDVH SURYLGH D FRSY RI \RXU LQVXUDQFH FDUG DQG SKRWR ,' DW WKH VDPH WLPH LQ WKH VDPH HQY

Student's Name: _____ Student ID No.: _____
Last First Middle

Birth Date: _____ Current Age: _____ Sex: _____ Country of Birth: _____

Home Address: _____
Street City State ZIP

Home Phone: _____ Cell: _____ Email: _____

Admission (Circle) Spring Summer Fall Year: ___ Major: _____

In case of emergency, please contact

1. Contact Name: _____ Relationship: _____
   Cell Phone: _____ Home: _____ Work: _____

2. Contact Name: _____ Relationship: _____
   Cell Phone: _____ Home: _____ Work: _____

Medical HistoryÑFamily

Parental Consent for Minor:
7KH DERYH QDPHG VWXGHQW KDV P\ SHUPLVVLRQ WR UHFHLYH VHUYLFHV DW WKI
0HGLFDO &HQWHU VWDII WKH 'UDNH 6WXGHQW +HDOWK &HQWHU LQ D FRQWUDFW
UHPDLQ LQ HIIHFW XQWLO P\ FKLOG LV \HDUV RI DJH $W WKDW WLPH , XQGHU
$ SDUHQW RU JXDUGLDQ FDQ UHYRNH WKLV SHUPLVVLRQ DW DQ\ WLPH

Signature of Parent/Guardian if Student is a Minor: _____ Date: _____

Drake University Student Health Immunization History

Obtain copies of your immunization records and attach to this form.

Examples of acceptable documents include:
- ¥ Copies of physician ofÞce or health department immunization records
- ¥ Copies of high school or previous college immunization records

(Please Þll in the dates below.)

Student Name:____ DOB:_________________________

Required immunizations

MMR (Measles, Mumps, Rubella) Ð 2 DOSES REQUIRED:

Proof of immunity to MMR is a requirement for registration for classes. This requirement is fulÞlled if you meet one of the following criteria:

¥ birth date before 1957

¥ or received two doses of MMR vaccine (provide both dates)
1:____ /___ /___ 2:___ /___ /___
second dose must be at least 28 days after Þrst dose.

¥ or received two doses of Measles, Mumps, Rubella vaccine (provide both dates)
Measles 1:____ /___ /___ 2:___ /___ /___
Mumps 1:____ /___ /___ 2:___ /___ /___
Rubella 1:____ /___ /___ 2:___ /___ /___

¥ or provide to Student Health Services copies of original lab reports of MMR titers that verify immunity to these diseases

Recommended Immunizations (but not required)

Tetanus/Diptheria/Pertussis (TDAP):

Booster (within past 10 years):____________

Varicella: (birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets requirement)

History of the disease:____ Yes___ No

Immunization: Dose 1:____ Dose 2:___

Hepatitis B Series:

Dose 1:____ Dose 2:___ Dose 3:

Hepatitis A Series:

Dose 1:____ Dose 2:___

Gardisal (HPV vaccine):

Dose 1:____ Dose 2:___ Dose 3:

Strongly Recommended if Living on Campus

Meningitis (Menactra):

Meningitis is an infection of the ßuid surrounding the brain and spinal cord that is caused by a virus or bacteria. Bacterial meningitis can be severe and cause organ damage and death. The Meningitis vaccine is recommended for college freshmen living in residence halls.

To make an informed decision about receiving the vaccine it is important to read the information provided at the following websites:

www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html
or
www.acha.org/topics/meningitis.cfm

Dose 1:____

Dose 2:____ (if Dose 1 was given before age 16)

If you have not received the meningitis vaccine you may sign a waiver: I am 18 years of age or older or the parent of a minor child. Drake University has provided me information explaining the risks of meningococcal disease and I am aware of the effectiveness and availability of the vaccine. I do not choose to get the meningococcal vaccine at this time.

____
Signature of student or parent/guardian

____
Date

To validate this form, have it signed and dated by your health care provider or authorized immunization ofÞcial or provide a copy of your immunization record.

Name of Health Care Provider:______________________________ Signature:______________________

Address: ____ Date (month/day/year): ____ /____ /___

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High Burden TB Country List 2020

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Country	Country	Country	Country
Afghanistan	Dominican Republic	Madagascar	Sao Tome and Principe
Algeria	Ecuador	Malawi	Senegal
Angola	El Salvador	Malaysia	Serbia
Anguilla	Equatorial Guinea	Maldives	Sierra Leone
Argentina	Eritrea	Mali	Singapore
Armenia	Eswatini (formerly Swaziland)	Marshall Islands	Solomon Islands
Azerbaijan	Ethiopia	Mauritania	Somalia
Bangladesh	Fiji	Mexico	South Africa
Bangladesh	French Polynesia	Micronesia (Federated States of)	South Sudan
Belarus	Gabon	Moldova (Republic of)	South Kor02 Tw 15636mRed [(So)-/MC

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