

# Health Record Form

Please type or print in ink.

Enrollment Year \_\_\_\_\_ Term:  Fall  Spring  Summer

## FOR OFFICE USE ONLY

ID \_\_\_\_\_  
 Form Complete  
Date \_\_\_\_\_

Student's Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Marital Status (S-M-D) \_\_\_\_\_

Date of Birth (MM-DD-YYYY) \_\_\_\_\_ Gender (M/F) \_\_\_\_\_ Citizenship \_\_\_\_\_ Social Security Number \_\_\_\_\_

Permanent Home Address \_\_\_\_\_ Student's Cell Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_ City/State \_\_\_\_\_ Phone \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_ Policy Number \_\_\_\_\_ Phone \_\_\_\_\_

**Please send a copy of both sides of your health insurance card, if available.** Although insurance is not accepted at the LCU Medical Clinic, all students are strongly encouraged to carry health insurance, in case of need for services provided outside of the Medical Clinic (e.g. blood tests, x-rays, specialist referrals, emergency/hospital care).

## REQUIRED IMMUNIZATIONS – Please provide documentation\* of the following:

### **Meningococcal Disease (Meningitis)** – Menactra (MCV4) or Menomune (MPSV4)

- Required by Texas law for all students under 30 years of age.  
Certain exceptions apply – see website for more info: [www.lcu.edu/meningitis](http://www.lcu.edu/meningitis)
- Vaccine must be received at least 10 days (but not more than 5 years) prior to first day of class.

### **Tetanus** – Primary series typically received in childhood.

- Booster required within past 10 years (Td or Tdap).
- Tdap preferred since 2005 to help protect against pertussis (“whooping cough”).

### **MMR** (Measles, Mumps, Rubella) – 2 shot series, usually received in childhood.

- Required if born after 1956.

### **Recommended Immunizations:**

- Hepatitis A, Hepatitis B
- Varicella (if never had chickenpox)
- Influenza (flu – annually)

### **\* Acceptable records demonstrating your immunizations may be obtained from any of the following:**

- Immunization Form verified by signature or stamp of a physician or other licensed health care professional.
- Official Immunization Record generated from a state or local health department.
- Immunization Record from High School or Previous College/University - Must have an official stamp or signature. These immunization records do not transfer automatically; you must request a copy

**Be certain that your name appears on each page of any records you submit.** Submitting all forms together is preferable. The records must include the dates of vaccine administration - including the month, day and year. All records must be in English. Please keep a copy for your records. If you have any questions, please call the LCU Medical Clinic at 806.720.7482 or visit our website at [www.lcu.edu/medical](http://www.lcu.edu/medical).

**MEDICAL INFORMATION** This information is requested to be available in the event of emergency, and will not be reviewed by admissions staff to determine eligibility for admission.

**Have you ever had any of the following? Please provide further explanations below as needed.**

- Allergic to:
  - Medication, specify: \_\_\_\_\_
  - Latex
  - Foods, specify: \_\_\_\_\_
  - Insect
  - Other: \_\_\_\_\_
  - Anaphylactic shock, Epipen (epinephrine) use
- Asthma
- Cancer
- Diabetes
- Depression / anxiety
- Other mental health issues
- Epilepsy / seizures / convulsions
- Fainting
- Head injury / concussion
- Heart disease or irregularity
- High blood pressure
- Handicap (visual, auditory, neurological, mental, musculoskeletal, etc.)
- Immune system disorder
- Tumor or cyst
- Severe menstrual problems
- Severe migraines
- Surgery (appendix, gall bladder, tonsils, etc.)
- Other: \_\_\_\_\_

If you have any further medical or surgical history that you find important for the medical staff to have on record, please provide details here (or attach further documentation if needed). \_\_\_\_\_

**Current prescription medications:** \_\_\_\_\_

### TUBERCULOSIS (TB) SCREENING QUESTIONS

Please answer the following questions:

1. Have you ever had a positive TB skin test? Yes  No
2. Have you ever had close contact with anyone who was sick with TB? Yes  No
3. Have you ever been vaccinated with BCG (tuberculosis vaccine given commonly outside the USA)? Yes  No
4. Were you born in, or within the past 5 years have you lived in or traveled for more than a month in, any country *other than* those listed below\*? Yes  No

\* American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, New Zealand, Norway, Saint Kitts and Nevis, Saint Lucia, San Marino, Sweden, Switzerland, United Kingdom, or USA.

**If the answer to all of the above questions is NO** then no further action is required.  
**If the answer to ANY of the above questions is YES**, then you will need further assessment performed by your health care provider or your local city health department. Please print out the form on our website ([www.lcu.edu/medical](http://www.lcu.edu/medical)) and return the completed form to the LCU Medical Clinic. Call 806-720-7482 with any questions.

To the best of my knowledge, I certify that the information provided on this form and all attached immunization records are accurate and complete.

I have received and reviewed the information provided to me by LCU regarding immunization requirements and recommendations, as well as information regarding bacterial meningitis (also available in the Student Handbook and at [www.lcu.edu/meningitis](http://www.lcu.edu/meningitis)).

I hereby grant LCU Medical Clinic staff the permission to administer medical and surgical services, immunizations, therapeutic procedures, and emergency medical services without liability. In the event of an emergency, I also authorize the LCU Medical Clinic to release (by fax, photocopy, or verbal communication) the information contained within this Health Record Form to the treating hospital, physician, and/or medical staff.

For all students age 17 or younger: \_\_\_\_\_  
Parent or Guardian Signature Date

For all students age 18 or older: \_\_\_\_\_  
Student Signature Date

**Please return to:**

**LCU Medical Clinic • 5601 19th Street • Lubbock, Texas 79407-2099**

**NOTE: You are encouraged to retain a copy of this form and your immunization records for your personal files.  
If you have any questions regarding the instructions or information within this form, please contact:  
LCU Medical Clinic 806-720-7482**