Medical History Form

Instructions and information:

1. We require this form be returned to the address below within 30 days or no later than 14 prior to enrollment. All pages must be completed.
2. We recommend this form be completed by all new students and students who have been away from the University for more than 10 months. We also recommend students entering graduate school complete this form.
3. Information on this form is **CONFIDENTIA**L. It is for Kentucky State University Student Health Services, will not be released without the student's consent and will not affect admission status.
4. Send completed forms to: Student Health Services
Kentucky State University
400 East Main Street
Frankfort, KY 40601
Fax: (502) 597-6565 or
Scan to: Samantha.Todd@kysu.edu

IDENTIFICATION

CWID # (see acceptance letter): _______________________ SSN: ____________________________________

Name (Last, First, Middle): ____

Home Address (Number and Street): ____

____
City State Zip Code Country

Home Telephone: ( ) ____

Cell Phone: ( ) ____

Email: ____

Date of Birth (Month-Day-Year): ____

Sex: ___Male ___Female

Emergency Contact Information (Name and Telephone Number – PLEASE PRINT):

____

MEDICAL HISTORY

Seizures: ____

Chronic Diseases: ____

Allergies: ____

Medications: ____

Significant Historical Information:
____

Required complete immunizations to submit:

- Polio Series (x4)
- Adult Tdap (not older than 10 years)
- Meningitis Vaccine (up to age 26) – Meningococcal Quadrivalent (A, C, Y, W-135) and Serogroup B Meningococcal Vaccine
- Mumps (MMR x 2 or documentation of disease)*
- Varicella Vaccine **x 2** or History of Chickenpox*
- Tuberculin Skin Test ***(INTERNATIONAL STUDENTS ONLY)***
- Hepatitis B Series x 3

**Note: Documentation of disease should be verified or signed on physician's/clinic's letterhead.*
Note: Documentation from Physician and Parent – NO Immunizations because of religion

Recommended immunizations include:

- Hepatitis A Vaccine
- HPV Vaccine
- Pneumococcal Vaccine

Must submit certificate from Doctor's office/clinic as documentation of proof of all immunizations to address or fax number on front.