All full-time, degree-seeking students entering John Brown University are required to submit this completed Health Form to the Health Services prior to final acceptance. This requirement applies to all new students, including transfers.

Purpose of Health Form:

- To provide information in the event of a medical emergency.
- To assist the Health Services by providing information that is not immediately obtainable from the student.
- To indicate conditions for which a student may need care or assistance from the Health Services.
- To assist persons with disabilities or chronic illness in making arrangements to facilitate their successful experience at John Brown University.
- To comply with Arkansas Law Acts 141 and 96

Instructions:

1. Please completely answer all questions.
3. “Immunization” sheet must be completed and signed by your physician, or accompanied by immunization records.
4. Transfer students may send copy of health records from previous university/college but still need to complete pp. 2-3.
5. Any significant illnesses, surgeries or immunizations between the time of completion of this form and registration for classes should be reported and records sent to the Health Services by the time of arrival at the university.
6. Mail or fax as soon as possible or bring completed health forms with you when you arrive.

   Health Services
   John Brown University
   2000 West University
   Siloam Springs, Arkansas 72761
   Fax: 479-524-1621

7. All full-time students must send completed health form prior to starting school or bring to registration. This is a requirement. You will not be allowed to complete the registration process without this.
Personal History

Information on this side is for use by the University Health-Counseling Disabilities staff, Vice President of Student Development, Associate Dean of Housing and Resident Directors as deemed applicable for your safety and well-being. The contents are confidential and will not be otherwise released without your knowledge and consent.

**Personal History:**

<table>
<thead>
<tr>
<th>Have you ever had</th>
<th>No</th>
<th>Yes (Current)</th>
<th>Yes (Previously)</th>
<th>Comments/Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
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<tr>
<td>Food</td>
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</tr>
<tr>
<td>Plant</td>
<td></td>
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<tr>
<td>Insect Bites</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Murmur/Problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Kidney Stones/Disease</td>
<td></td>
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</tr>
<tr>
<td>Convulsions/Seizures</td>
<td></td>
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<tr>
<td>Visual Problems</td>
<td></td>
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<tr>
<td>Hearing Loss</td>
<td></td>
<td></td>
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<tr>
<td>Arthritis</td>
<td></td>
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<tr>
<td>Malaria</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Hypoglycemia</td>
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<tr>
<td>Thyroid Disease</td>
<td></td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Anorexia/Bulimia</td>
<td></td>
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<td></td>
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<tr>
<td>Hepatitis A, B, C</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Tuberculosis + skin test, when treated</td>
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<td></td>
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<tr>
<td>Rheumatic Fever</td>
<td></td>
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<tr>
<td>Bleeding Disorder</td>
<td></td>
<td></td>
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<tr>
<td>HIV Positive</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td></td>
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<tr>
<td>Headaches/Migraines</td>
<td></td>
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<tr>
<td>Emotional Disturbance</td>
<td></td>
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<tr>
<td>Epilepsy</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Do you have a medical disability?  □ No  □ Yes  Explain ______________________

Are you under a physician’s care now?  □ No  □ Yes  Explain ______________________

☐ Laboratory Monitoring  ☐ Other ______________________

List any prescription medications taken on a frequent or regular basis:  
(name, dosage, frequency, reason) ______________________

Do you use syringes for self medication?  □ No  □ Yes 
Health services will provide Free “sharps” containers and disposal of contents. 
Is there anything Health Services should know in order to give you better health care? ______________________

Are there any existing health conditions that might need medical attention or monitoring such as special diets, medication levels, etc.? ______________________

In order to maintain continuity of care, a letter of medical explanation or copies of medical records pertinent to any previous medical condition that might reoccur should be attached or mailed to Health Services to remain in their permanent chart in case it is needed.
Personal Information and Authorization

Information on this page may be copied and released to the Arkansas Health Department for compliance audit and, as needed on your behalf, to the University staff and area medical facilities in the event of a health or safety emergency.

Name ___________________________ Birth Date __________

Social Security # ___________ Phone ( ) ___________ M □ F □ Marital Status ______

Home Address __________________________________________

Email Address __________________________________________

EMERGENCY NOTIFICATION:

Parent/Guardian/Spouse

1. Name ____________________________________ Day Phone ( ) ___________________
   
   Evening Phone ( ) _______________________
   
   Name ____________________________________ Day Phone ( ) ___________________
   
   Evening Phone ( ) _______________________

Alternate Emergency Contact

2. Name ____________________________________ Day Phone ( ) ___________________
   
   Relationship ____________________________ Evening Phone ( ) ___________________

Insurance Company Name: __________________________ Policy Holder Name: __________________________

Insurance Address: __________________________ Policy Holder Birthday: __________________________

Insurance Phone: __________________________ Policy Holder SS#: __________________________

Policy #: __________________________________

AUTHORIZATIONS: PERMISSION FOR TREATMENT

Consent is given for treatment in the University Student Health Service by licensed personnel for routine health (physical or mental) care, assessment, treatment, and if necessary, referral or hospitalization. If health care is needed in the absence of Health Service personnel, a college representative may choose local medical personnel on my behalf.

No guarantee has been made to me as to the results to be obtained by treatment given to me.

It is understood that the University will contact the designated, authorized person(s) in the case of an emergency or serious illness (physical or mental).

I understand that I will be responsible for charges incurred due to illness, injury, or accident.

SIGNED:

________________________________________________________________________

Student Date ______________

________________________________________________________________________

Parent or Guardian (if student is not 18 years) Date __________________
Immunity as designated below is required by university prior to entrance.

All students must have a documented history of Measles, Mumps, Rubella. Immunization records* from doctor’s office, health department, or school records will be accepted in lieu of signature below.

*All records not in English must be accompanied by a certified translation.

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthday</th>
<th>M.M.R. (Measles, Mumps, Rubella) (Two doses required.)</th>
<th>Tetanus-Diphtheria</th>
<th>Tuberculosis Screening (PPD required regardless of prior BCG inoculation.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Dose 1 given at age 12-15 months or later</td>
<td>1. Tetanus- Diphtheria Series complete:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Dose 2 given at age 4-6 years or later, and at least one month after first dose.</td>
<td>2. Tetanus (Td) booster within the last ten years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Dose 1 given at age 12-15 months or later</td>
<td>2. If PPD is positive x-ray must be documented on official state form.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.</td>
<td>Call 479-524-7320, fax 479-524-1621, e-mail: <a href="mailto:maguinn@jbu.edu">maguinn@jbu.edu</a>, <a href="http://www.jbu.edu/life/studev/health/">www.jbu.edu/life/studev/health/</a></td>
<td></td>
</tr>
</tbody>
</table>

**Tuberculosis Screening (PPD required regardless of prior BCG inoculation.)**

Due to new Arkansas Law regarding Act 96 of 1913, the university now requires all incoming students who were born or have lived for longer than 6 months in countries where Tuberculosis is endemic to show documentation of a TB skin test. **Skin testing must be done within the United States.** We continue to strongly recommend that all incoming students be tested within the past 1-2 years.

All Students must complete this section

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Country lived in more than 6 mos</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. PPD (Mantoux) (tine or monovac not acceptable)

   Result: Neg _____ Pos _____ mm induration (horizontal diameter) _______ _____/_____/_____

2. If PPD is positive x-ray must be documented on official state form. Call 479-524-7320, fax 479-524-1621, e-mail: maguinn@jbu.edu, www.jbu.edu/life/studev/health/

**Polio Booster**

# ______ in Series _____/_____/_____

**Recommended:**

**Varicella**

1. History of Disease  
   - Yes  
   - No  

   Dose #1 ..................................................................................................................................... _____/_____/_____
   
   Dose #2, given at least one month after first dose, if age 13 years or older ................... _____/_____/_____

**Hepatitis B Vaccine**

Dose #1 _____/_____/_____  
Dose #2 _____/_____/_____  
Dose #3 _____/_____/_____  

**Hepatitis A Vaccine**

Dose #1 _____/_____/_____  
Dose #2 _____/_____/_____  

**Meningitis Vaccine**

Dose #1 _____/_____/_____  

**HPV Vaccine**

Dose #1 _____/_____/_____  
Dose #1 _____/_____/_____  
Dose #1 _____/_____/_____  

Signed __________________________  
Dated __________________________

Health Care Professional (Doctor, Nurse, Nurse Practitioner, P.A.)