MILLSAPS COLLEGE
WESSON HEALTH CENTER
Health History Form

Full Name _____
(last) (first) (middle)

Preferred_____ Student ID # _____

Gender: (please circle) Male Female Gender Non Conforming

What is the student's first year enrolled at Millsaps College? 20_____

Date of Birth _____

Home Address _____ Cell Phone _____

City _____ State_____Zip_____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian _____ Parent/Guardian _____

Cell Phone _____ Cell Phone _____

Emergency Contact (if different from above)

_____
(Last) (First) (Middle) (Cell Phone) (relationship to student)

TO THE APPLICANT AND THE PHYSICIAN:

The Health History Form is ***required*** for all entering students to complete registration. Please fill out the Health History Form. In order to render more efficient medical care to Millsaps students, the Wesson Health Center staff must have an accurate and comprehensive record of each student's present and past medical experience. Any condition which might affect the student's academic progress or require special attention should be reported. Effort will be made to facilitate continuation of a plan of treatment for the welfare of the student if specific instructions are furnished by the personal physician. Please note the Wesson Health Center *DOES NOT* file claims to the student's medical insurance.

The Mississippi State Board of Health in conjunction with the Board of Trustees of the Institutions of Higher Learning require that all new and transfer students must show proof of documented history of two doses of MMR (measles, mumps, rubella) vaccine. It is VERY IMPORTANT that you complete your immunization information. *Please note that documentation must be from a healthcare provider (family physician, health department, etc.).*

This form is used as a permanent record during the student's entire time at Millsaps and is strictly confidential.
If you have any questions, please call the Office of Student Life at 601-974-1200.

THIS FORM MUST BE COMPLETED BY AUGUST 1.

Please upload your immunization records to https://millsaps.medicatconnect.com/
You may also scan and email to health@millsaps.edu or mail to:
Wesson Health Center, Millsaps College, Box 151063 1701 N. State Street, Jackson, MS 39210.

Do not turn this form into any other office or department.

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Student Name _____
(Last) (First) (Middle)

HEALTH QUESTIONNAIRE

Personal Medical History: Please provide date (month/year) of the following medical issues and note if an ongoing medical condition:

Asthma	Hypertension	Hepatitis
Seizures	Sleep Difficulty	Anemia
Kidney Disease	Fainting/Dizziness	Frequent Ear Infection
Digestive Disorders	Bone/Joint Problems	Diabetes
Chicken Pox	Eating Disorder	Infectious Mono
Learning Disability	Heart Disease	Hyperactivity
Cancer	Seasonal Allergies	Severe Headaches/Migraine
Attention Deficit Disorder	Menstrual Difficulties	STD's

Have you received treatment or counseling for alcohol or drug abuse, eating disorder, depression, or other mental health issue?

_____

Do you wear glasses or contact lenses? Yes____ No ____ All the time ____ Reading only_____

Medications taken regularly:

_____
(prescription name) (dosage) (frequency)

_____
(prescription name) (dosage) (frequency)

Medications taken periodically

_____
(prescription name) (dosage) (frequency)

_____
(prescription name) (dosage) (frequency)

List medication allergies: _____

Other allergies: _____

Do you use tobacco products or vape? _____Yes _____No

Are you covered by medical insurance? _____ If yes, what company? _____

Subscribers name: _____

Insurance Number

_____

Do you know of any reason why you will not be able to participate in all college activities, including athletics?

If yes, give reason _____

EMERGENCY CONSENT FOR MINORS – Signatures Required

Students under 18 years of age cannot give legal consent to be treated in case a medical or psychological emergency arises. In such cases, are you willing to give permission for emergency treatment to be administered?
_____ Yes _____ No

Signature of parent or guardian _____Date _____

Signature of student _____Date _____

Certificate of Immunization Compliance

Millsaps ***requires*** documentation of 2 MMR's – 1st after 12 months of age, 2nd at 5 years old or later. **Meningococcal, COVID-19 and Influenza vaccines are strongly recommended.** Tetanus boosters are also strongly recommended.
The Wesson Health Center staff will follow up on this to ensure documentation is provided. **Students will not be allowed to attend class if this form is missing from the Wesson Health Center records.**

Name of Student _____ Birthdate _____

Millsaps College Student ID #_____

Address _____
Street City State Zip

	Date Each Dose Was Given				
Vaccine	**1st**	**2nd**	**3rd**	**4th**	**5th**
DTP/DTaP/DT/Td					
MMR					
Meningococcal (MenACWY or MENB)					
Varicella					
COVID-19					
Hepatitis-B					

Health Dept. or Clinic Signature _____

Date Form Completed _____

INTERNATIONAL STUDENTS ONLY: Millsaps ***requires*** documentation of TB Blood Test within the past year.

TB Blood Test: Date Given _____ Date of Results _____ ☐ Positive ☐ Negative

If Positive, CXR Date _____ Results _____

Treatment _____

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