

MEDICAL HISTORY REPORT  
STUDENT HEALTH SERVICE  
LOYOLA UNIVERSITY CHICAGO

**Medical Center Campus**  
1211 West Roosevelt Road  
Maywood, IL 60153  
708/531-7900

Name (Last) \_\_\_\_\_ First \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Circle: Female Male  
Permanent (Home) Address  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_  
Emergency Contact Person \_\_\_\_\_ Relation to Student \_\_\_\_\_ Phone \_\_\_\_\_  
To be completed during new student orientation unless you have already procured local housing  
Address while attending Loyola \_\_\_\_\_ Apt. # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
School Mail Box #  
COLLEGE CODE (Circle One)                      08 Graduate School                      20 Medical School

**HISTORY**

**MEDICAL:** (asthma, arthritis, anemia, hypertension, diabetes, cancer, heart, lung, kidney, thyroid, tuberculosis, mental illness, or any other chronic medical conditions). **If none, please note; if yes, please list:**

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**SURGICAL PROCEDURES: If none, please note; if yes, please list:**

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**ALLERGIES:** (medications, foods, latex, animals, chemical seasonal, environmental) **If none, please note; if yes, please list:**

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**MEDICATIONS:** (taken on a daily or as needed basis) **If none, please note; if yes, please list:**

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**IMMUNIZATION RECORD**

- IUHS Student Health Services policy requires that all incoming students provide documentation of serologic evidence of immunity (i.e. positive

IgG) against measles, mumps, rubella, and varicella. If serology is negative, you must provide the laboratory report and proof of vaccination.  
 - A negative TB skin test (PPD) within the three months preceding matriculation is required. If skin test positive, documentation of a negative chest x-ray within 12 months of matriculation is required.

- Provide documentation of all previous Polio and Tetanus vaccinations, including a tetanus booster (Td or Tdap), within the past 10 years.

- Provide documentation of serologic evidence of immunity (i.e. positive IgG) against Hepatitis B. Students who opt not to be vaccinated against Hepatitis B will be required to sign a Declination of Vaccination form.

1. **Copies of all serology reports must be submitted.**

2. **Vaccination records must be signed by a health care provider** (i.e., M.D., D.O., R.N., or other public health official). Vaccination dates must include Month, Day and Year. Copies of original records may be submitted as proof of vaccination.

3. The following exemptions will be accepted and statements must accompany this record.

**Medical contraindication:** a written, signed and dated statement from a physician citing the vaccine(s) contraindicated and duration of medical condition that contraindicates the vaccine(s).

**Religious exemption:** a written signed and dated statement by the student describing the objection to immunization based upon bona fide religious tenets or practice.

**Pregnancy or suspected pregnancy:** a signed and dated statement by the health care provider that the student is pregnant or pregnancy is suspected.

Anyone with a vaccine exemption may be excluded from the university setting in the event of outbreaks.

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

5. Any questions may be directed to Student Health Services at 708/531-7900.

Serology Date & Result		Vaccine Date	Exemption
<b>Measles (Rubeola)</b>	Date _____ Result _____	dose 1 _____ dose 2 _____	
<b>Mumps (Parotitis)</b>	Date _____ Result _____	dose 1 _____ dose 2 _____	
<b>German Measles (Rubella) or</b>	Date _____ Result _____	dose 1 _____	
<b>MMR</b>		dose 1 _____ dose 2 _____	
<b>Diphtheria/Tetanus</b>	Primary series DPT or DT dose 1 _____ dose 2 _____ dose 3 _____ dose 4 _____	Tetanus boosters _____ _____	
<b>Polio</b>	dose 1 _____ dose 2 _____ dose 3 _____ dose 4 _____	Polio booster _____ _____	
<b>TB Screen</b>	date _____ result _____ mm of induration	CXR if indicated/result	
<b>Chickenpox (Varicella)</b>	Serology date & result Date _____ Result _____	Vaccine dates Dose 1 _____ Dose 2 _____	Exemption
<b>Hepatitis B</b>	Serology date & result Date _____ Result _____	Vaccine dates Dose 1 _____ Dose 2 _____ Dose 3 _____	Exemption

Signature of Health Care provider verifying above information \_\_\_\_\_

Print Name \_\_\_\_\_

Address & Phone \_\_\_\_\_