San Antonio, Texas 78228-5104
Phone: (210) 732-2156 Fax: (210) 732-9072
Email: macc@maccsa.org Web: www.maccsa.org

HEALTH RECORD

PLEASE ANSWER ALL QUESTIONS.
Type or print answers. This information is **CONFIDENTIAL** and will not be released without your written consent. Return this form to: Mexican American Catholic College, 3115 West Ashby Place, San Antonio, Texas 78228, Phone (210) 732-2156.

OFFICE USE ONLY
Date Received_____
Health Record ☐
Immunizations ☐
Insurance Card ☐

CLASSIFICATION
Date Enrolled_____
First Year ☐
Sophomore ☐
Junior ☐
Senior ☐
Graduate ☐
Transfer ☐
International ☐

Student Name____
Last *First* *Middle*
Social Security No.___-___-___ Date of Birth________Gender___Married_______
Home Address____
City____________________________________State__________Zip_______
Phone No.( )____-_______Citizenship_______ Are you a military dependent?____

Please Circle: Parent, Guardian or Spouse Fill in the rest of this box.

____
Last First Middle

Home Address:____
City_____________________________State______________Zip____________
Phone No.____
(Daytime) (Evening)

FAMILY HISTORY
Father Living Deceased
Age at Death ____________________
Cause of Death ____________________
Occupation ____________________
Mother Living Deceased
Age at Death ____________________
Cause of Death ____________________
Occupation ____________________
Siblings Number Living___ Number Deceased_____
Age of Death ____________________
Cause of Death ____________________

Have any of your relatives had any of the following?

Circle Yes or No		Relationship (if yes)
No	Arthritis	Yes____________________
No	Asthma	Yes____________________
No	Heart Disease	Yes____________________
No	Cancer	Yes____________________
No	Diabetes	Yes____________________
No	Seizure Disorder	Yes____________________
No	Emotional Illness	Yes____________________
No	Tuberculosis	Yes____________________
No	Other: Specify	Yes____________________

Personal Medical History: **Have you had or do you have**:

- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Heart Disease
- ☐ Kidney/Bladder Disease
- ☐ Bone Joint Disease
- ☐ Sexually Transmitted Disease
- ☐ Seizure/Blackouts
- ☐ Peptic Ulcer
- ☐ Eating Disorder
- ☐ Chicken Pox
- ☐ Bleeding Disorder
- ☐ Hepatitis/Jaundice
- ☐ Recent Weight Change
- ☐ Infectious Mononucleosis
- ☐ Psychiatric Treatment
- ☐ Wear Contact Lenses
- ☐ Wear Hearing Aid
- ☐ Menstrual Problems
- ☐ Scarlet Fever
- ☐ German Measles (Rubella)
- ☐ Measles
- ☐ Mumps
- ☐ Malaria

ALLERGIES
- ☐ Penicillin
- ☐ Sulfa
- ☐ Codeine

Name:____

Last **First** **Middle**

<u>Personal</u> **Medical History**	**<u>Have you had or do you have?</u>**	**<u>Allergies</u>**
☐ Anxiety/Depression	☐ Other Handicaps/Needs	☐ Aspirin
☐ Head Injury	☐ Tonsillectomy	☐ Foods
☐ Recurrent Headaches	☐ Appendectomy	☐ Seasonal Pollen
☐ Hi/Lo Blood Pressure	☐ Hernia Repair	☐ Wasp/Bee Stings
☐ Gum/Dental Disorder	☐ Other Operations	☐ Other:

Please comment on any checked boxes: (Include explanation and dates of illness.) ________________
____
____
____
____

The following section should be filled out **in blue ink** by a licensed physician.
Immunizations:
1. **Tetanus-Diphtheria** (td) ___/___/___ or Adacel (Tdap)___/___/___ *Must have received within past 10 years.*
2. **Measles, mumps and rubella (MMR)** Dose 1___/___/ Dose 2 ___/___/___
3. **Polio Series** (required if less than 18 years old): Completion date: ___/___/___ Oral or injectable vaccination series is acceptable.
4. **Tuberculosis:** Testing must be done regardless of previous BCG Inoculation. The Mantoux test must be used (not the tine). If PPD is positive, then a chest X-ray within one year is required. The result of a PPD skin test must be within 12-month period prior to starting at the Mexican American Catholic College: Date of skin test reading ___/___/___
Reading at 48-72 hours: Negative ______ Positive (mm) _____
Date and result of chest X-ray ___/___/___

Recommended:
Menomune Date received ___/___/___ or Menactra Date received ___/___/___
Hepatitis A Vaccination
Dose 1 ___/___/____ Dose 2 ___/___/___
Hepatitis B vaccination
Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

I have examined the patient named above. At the time of the exam this person was healthy. Travel is not restricted. I verify that the immunizations checked have been administered to the patient for travel to the United States of America.

/ / /
____
Print Physician's Name Physician's Signature Physician's License Number Date

STATEMENT OF AUTHORIZATION

I authorize the Mexican American Catholic College to keep this form on file. MACC will refer me to a medical clinic in case I am in need of medical services or routine or emergency diagnostic and therapeutic procedures as deemed necessary by a duly licensed medical personnel at the clinic. Upon request, I will be given a copy of this form by the MACC Registrar for the physician at the clinic.

Student Signature____ Date______________

Parent/Guardian signature if student is under 18________________________ Date ______________