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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, or P.O. Box 28185, San Antonio, Texas 78228, Phone (210) 732-2156 ext. 7102.

OFFICE USE ONLY	
Date Received _____	
Health Record <input type="checkbox"/>	
Immunizations <input type="checkbox"/>	
Insurance Card <input type="checkbox"/>	
CLASSIFICATION	
Date Enrolled _____	
First Year <input type="checkbox"/>	
Sophomore <input type="checkbox"/>	
Junior <input type="checkbox"/>	
Senior <input type="checkbox"/>	
Graduate <input type="checkbox"/>	
Transfer <input type="checkbox"/>	
International <input type="checkbox"/>	

Student Name _____		
<i>Last</i>	<i>First</i>	<i>Middle</i>
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: <input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Heart Disease <input type="checkbox"/> Kidney/Bladder Disease <input type="checkbox"/> Bone Joint Disease <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Seizure/Blackouts	Have you had or do you have: <input type="checkbox"/> Peptic Ulcer <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Hepatitis/Jaundice <input type="checkbox"/> Recent Weight Change <input type="checkbox"/> Infectious Mononucleosis <input type="checkbox"/> Psychiatric Treatment <input type="checkbox"/> Wear Contact Lenses <input type="checkbox"/> Wear Hearing Aid	<input type="checkbox"/> Menstrual Problems <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> German Measles (Rubella) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Malaria ALLERGIES <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa <input type="checkbox"/> Codeine
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Name: _____

Last

First

Middle

Personal Medical History

- Anxiety/Depression
- Head Injury
- Recurrent Headaches
- Hi/Low Blood Pressure
- Gum/Dental Disorder

Have you had or do you have?

- Other Handicaps/Needs
- Tonsillectomy
- Appendectomy
- Hernia Repair
- Other Operations

Allergies

- Aspirin
- Foods
- Seasonal Pollen
- Wasp/Bee Stings
- 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 _____