The Restaurant School at Walnut Hill College

Health History

Last Name **First Name** **MI** **Social Security Number**

THE FOLLOWING SECTIONS MUST BE COMPLETED AND SIGNED BY YOUR PHYSICIAN OR HEALTHCARE PROVIDER:

Allergies (including those to medications) and Reaction:	Medications Taken Routinely:
Emotional Disturbances:	Past Surgeries (Major and Minor)
Serious Illnesses/Injuries/Chronic Diseases	Significant Family Medical History

Required Immunizations and Screening

Completion mandatory; to be completed by health care provider

Attention: Walnut Hill College students are required to document immunization to measles, mumps, and rubella. All questions in this section must be completed. Only information signed by a health care provider or copies of official records (such as school immunization records) will be accepted. Please indicate by month, day, and year the dates of vaccinations, diagnoses, or laboratory tests. The health care provider must verify all of those dates. (Note: Students born in 1956 or before are exempt from the measles, mumps, rubella requirement).

1. **Measles, Mumps, Rubella. Two (2) Immunizations for measles and one (1) each for mumps and rubella are required. The earliest the first immunization can be given is 12 months of age.**

   1st Immunization Month, Day & Year Received Measles (Rubeola) ___/___/___ Mumps ___/___/___ Rubella ___/___/___
   2nd Immunization Month, Day & Year Received MMR ___/___/___ OR Measles (Rubeola) ___/___/___
   Or physician diagnosed disease: Measles (Rubeola) ___/___/___ Mumps ___/___/___ Rubella ___/___/___
   Or documented positive titer Measles (Rubeola) ___/___/___ Mumps ___/___/___ Rubella ___/___/___

2. TB screening within the past year is **required** of all students at high risk for TB as defined by the CDC (foreign born persons from high prevalence countries, persons with compromised immune systems, close contacts of infectious TB cases, etc.)

   TB Skin Test (PPD) Date_____ Results _____
   mm induration

   If >5mm induration, date and results of last chest x-ray (must be within one year) _____
   If indicated, INH Therapy: Yes/No If yes _____
   Date began Date Completed

Suggested Immunizations and Screening

1. Tetanus/Diphtheria (booster must be given within the last 10 years) Date Received ____/____/____
2. Hepatitis B Vaccine (include dates) ____/____/____ ____/____/____ ____/____/____
   Month Day Year (1st Date) Month Day Year (2nd Date) Month Day Year (3rd Date)
3. Polio (include date of last booster) _____
4. Varicella (Chickenpox) vaccine
   Had Disease? Yes / No
   If no: 1st Immunization Month, Day & Year Received ___/___/___ 2nd Immunization Month, Day & Year ____/____/____
5. Menomune® (meningitis) vaccine Month, Day & Year Received ____/____/____

_____ _____
Signature (Physician or other Health Care Provider) Date
Health Care Provider, please attach business card