BETHANY COLLEGE HEALTH RECORD

HEALTH RECORDS ARE REQUIRED FOR ALL BETHANY STUDENTS

Please complete this form, **make a copy for your records**, and return to:

Student Health #59, Bethany College, 31 East Campus Drive, Bethany, WV 26032 or fax to 304-829-7788

Student Name_____Nickname_____

Birth Date_____ Social Security #_____

Home Address_____
(Street)

_____
(City) (State) (Zip Code)

Home Phone_____ Student's Cell Phone Number_____

Student's WhatsAPP Number: _____

Name of Parent/Guardian_____

In Case of Emergency Notify: Name: _____

Relationship _____ Phone Number: _____

Email Address _____ WhatsAPP Number: _____

MEDICATION ALLERGIES_____

MEDICATIONS_____

Any significant past medical history_____

_____

IMMUNIZATION DATES **THE FOLLOWING VACCINATION DATES ARE REQUIRED!**

POLIO Dates: _____ _____ _____ _____

DPT Dates: _____ _____ _____ _____

TETANUS BOOSTER (**within the last 10 years**) Date: _____

MMR (measles, mumps & rubella) two doses are required for all persons born AFTER 1957

1st Dose Date: _____ 2nd Dose Date (school age) _____

MENINGITIS VACCINE Date(s): _____

The following vaccines are suggested but **NOT** required:

CHICKEN POX (VARICELLA) History of Disease (check one): ☐ Yes ☐ No

Varicella Immunization Dates: 1st Dose Date: _____ 2nd Dose Date: _____

Hepatitis B Vaccine Dates: _____ _____ _____

Hepatitis A Vaccine Dates: _____ _____

COVID 19 Vaccine Date(s): _____

TURN FORM AROUND TO COMPLETE BACK

Insurance information

Name of Insurance Company: _____

Policy Number(s): _____

Who is the Insured: _____

Student's signature_____Date_____