MILLIKIN UNIVERSITY®

MILLIKIN-DMH HEALTH CLINIC

1184 West Main Street
Decatur, Illinois 62522

217.424.6360
217.422.5542
www.millikin.edu

HEALTH SERVICE REPORT

A completed Millikin Health Report is required on every student. This record includes consent for treatment, a medical history, and your immunization record. This information is required by the Illinois College Student Immunization Act 110 ILCS20, and must be submitted prior to starting classes. A healthcare professional must sign the immunization record, and it must contain the dates of immunization. Here are some helpful hints for locating your immunization record:

» The High School from which you graduated (All Illinois High Schools mandate compliance)
» Personal Physician
» Public or County Health Department
» Human Resource Department of Employer

Mail Completed Form To:
Millikin-DMH Health Clinic
1184 West Main Street
Decatur, IL 62522

Date Report Due: For Fall Semester enrollment, form must be received by July 15
For Spring Semester enrollment, form must be received by January 5

GENERAL INFORMATION

Have you attended Millikin previously? If yes, when?

Type of Student:
Undergraduate ◯ Graduate ◯ PACE ◯

Student Name: (Please Print) Last First MI

Year Entering: _____
Semester: Summer ◯ Fall ◯ Spring ◯

Student Permanent Mailing Adress: Street Address: Apt:

Millikin ID #:

City: State: Zip Code:

Date of Birth:

Gender:

Student Email Address:

Home Phone #:

Student Cell #:

EMERGENCY CONTACT

Name:

Relationship:

Home Phone #:

Work #:

Cell #:

STATEMENT OF AUTHORIZATION

I authorize Millikin Health Services to administer medical and surgical services (including immunizations and allergy injections), to perform emergency procedures, and/or defer treatment to a local physician or hospital if deemed necessary.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian (if Student is under 18) Date

***If a student is noncompliant, they will be unable to register for the subsequent semester.**

INSURANCE DATA

Health Insurance: Millikin University does not have a student health insurance policy. You are responsible for your own health insurance plan. We suggest you carry a copy of your insurance card. For your convenience, charges for services performed at the Health Clinic will be billed to your health insurance plan. The uncovered portion of the charges will be billed to you at your home address on file. If you do not have health insurance, charges will be directly billed to you at your home address on file. Payment for medications dispensed at the Health Clinic are due at the time of your visit. We accept cash, check, Visa, Mastercard and Discover.

I carry hospitalization and/or sickness and accident insurance Yes ☐ No ☐

Name of Insurance Company: _____ Phone #: ( ) _____

Address: _____ Group/Policy #: _____

Name of Subscriber: _____ Relationship to Student: _____

Subscriber Date of Birth: ___ / ___ / _____ ID #: _____

Check with your Insurance Company on the following:

Prescription Coverage:

Are you covered under a prescription program? Yes ☐ No ☐

Does it specify a pharmacy? If yes, please list. _____

Preferred Local Hospital: ○ Decatur Memorial Hospital ○ St. Mary's Hospital ○ None

Occasionally you may need to receive medical treatment at a local walk-in clinic. We recommend DMH Express Care. Does your insurance provide coverage there? Yes ☐ No ☐

PERSONAL MEDICAL HISTORY

The information that you provide in this section is kept confidential in the University Health Clinic and used by our medical staff to provide appropriate medical evaluation and care. Indicate whether you have had or are currently being treated for the following medical conditions. Attach a separate sheet to give details.

Name of your personal physician: _____

Are you currently trying to lose weight? Yes ☐ No ☐

HT _____ WT _____

Allergies?	YES	NO	Have you had? Family history of?	YES NO	Family	Have you had? Family history of?	YES NO	Family
Penicillin			Chicken Pox			Seizures/Epilepsy		
Sulfonamides			Eating Disorder			Rheumatic Fever		
Codeine			Arthritis			Heart Murmer/Click		
Other Medications _____			Immunodeficiency Discorder			Asthma/Hay Fever		
Bees/Wasps			Thyroid Disorder			Tuberculosis		
Foods			Diabetes			Migraine/Headaches		

Allergies?	YES	NO	Have you had? Family history of?	YES NO	Family	Have you had? Family history of?	YES NO	Family
Other _____ _____ _____			Low blood sugar			Tumor/Cancer/Cyst		
			ADD/ADHD			Hepatitis		
Do you receive allergy shots?			Low or high blood pressure			Heart Disease or Heart Attack		

Surgeries? List type of surgery and date of surgery. _____

_____

_____

_____

Have you had any illness, injury or hospitalization other than those previously noted? If yes, please give details.

_____

_____

_____

_____

Have you received treatment or counseling for depression, nervous condition, personality disorder, emotional problems, substance abuse or eating disorder? If yes, please give details.

_____

_____

_____

Do you take any medications routinely, including prescription, over the counter and/or herbal? If yes, provide a list and diagnosis.

_____

_____

_____

_____

_____

_____

CERTIFICATE OF IMMUNITY (to be completed by a Health Care Provider):

In accordance with Illinois College Student Immunization Act 11TLCS 20, Millikin University requires verification of immunity for Diphtheria/Tetanus, Measles, Mumps, and Rubella. Exact dates are required for all immunizations, date of disease and/or serological test results. If serology titer indicates lack of immunity, vaccines must be administered. Immunizations administered prior to the first birthday are invalid.

Exemptions: (1) Age; persons born before January 1, 1957 do not need to submit a Certificate of Immunity
(2) Medical Contraindictions: submit detailed documentation from a physician
(3) Religious Exemption: call our office to request a form or print the form from our website at **millikin.edu/wellness**.

Student Name: _____ Date of Birth: ___ / ___ / ___
Last First M

Student ID #: _____

MMR (Measles, Mumps, Rubella)_____
Two doses required, at least one month apart, after 12 months of age AND after 5-1-71 #1 ___ / ___ /___ #2 ___ / ___ / ___

IF MMR WAS NOT GIVEN, INDIVIDUAL IMMUNIZATIONS SHOULD BE LISTED

Measles (Rubeola, hard, red, 10 day)
1. Two doses required, at least one month apart, after 12 months of age AND after 1-1-68 #1 ___ / ___ / ___ #2 ___ / ___ / ____
OR 2. Date of disease diagnosed and certified by a physician #1 ___ / ___ / ___ .
OR 3. Serology test results proving immunity **attach lab report**

Mumps
1. One dose required, after 12 months of age AND after 1-1-68 #1 ___ / ___ / ___ #2 ___ / ___ / ____
OR 2. Date of disease diagnosed and certified by a physician #1 ___ / ___ / ___ .
OR 3. Serology test results proving immunity **attach lab report**

Rubella (German Measles, 3 day)
1. One dose required, after 12 months of age AND after 1-1-68
OR 2. Serology test results proving immunity #1 ___ / ___ / ___ .
attach lab report

Meningococcal All new admissions under the age of 22, receive 1 dose of Meningococcal conjugate vaccine on or after 16 years of age. #1 ___ / ___ / ___

TD (Tetanus/Diphtheria) -
1. U.S. Citizens - vaccination of 1 dose within the last 10 years #1 ___ / ___ / ___
2. International Students - vaccination of 3 doses within the past 10 years

International Students - Tuberculosis Screening
Must have regardless of history of BCG vaccine. A mandatory TB Mantoux skin test will be done at the University Health Clinic upon your arrival to campus. Chest X-rays may be required to determine treatments needs. All costs are the responsibility of the student.

Optional recommended Vaccines, but not required,

Hepatitis B Vaccine #1 ___ / ___ / ___ **#2** ___ / ___ / ___ **#3** ___ / ___ / ___
Hepatitis A Vaccine #1 ___ / ___ / ___ **#2** ___ / ___ / ___ **#3** ___ / ___ / ___
HPV #1 ___ / ___ / ___ **HPV #2** ___ / ___ / ___ **HPV #3** ___ / ___ / ___
Varicella Vaccine #1 ___ / ___ / ___

Health Provider (physician, school health professional or other health official verifying immunizations)

_____ Date _____ Phone ( )_____
Signature Title