

Name						
LAST	FIRST			MIDDLE		
AddressSTREET	CITY		ST	ATE	ZIP CODE	
Phone ()	_	Gender:	□Male	□Female		
IMMUNIZATION RECORD FOR STUDENTS ATT	ENDING POS		DARY SC	HOOLS AS	REQUIRED BY	
Minnesota law (MS135A.14) requires that all students born after 1956 and diphtheria, tetanus, measles, mumps, and rubella. This form is designed to by the Minnesota Department o	d enrolled in public or provide the school	r private post-so with information	n required by			
Immunizations						
All dates must include month, day (if available), and year. A	copy of your im	munization r	ecord wou	ıld be preferre	ed.	
<u>IMMUNIZATION</u>		MO	NTH/D	AY/YEAR		
TETANUS/DIPHTHERIA (TD) Within the past 10 years - required by Minnesota Law			_			
MEASLES/MUMPS/RUBELLA (MMR) Two doses after 12 months of age - required by Minnesota Law						
HEPATITIS A A two dose series is recommended for certain persons at increased risk an wishing to obtain immunity, especially international travelers	nd others			 		
HEPATITIS B Persons at increased risk should have completed a three dose series						
MENINGOCOCCAL <u>Recommended</u> for students who live in dormitories to reduce their slightly risk of disease	/ increased		_			
Medical Information						
In order to better meet your needs as a student of Crossro these questions are an infringement on your personal rights, please write "N/A" in the blank.						
LIST ANY CHRONIC OR SERIOUS ILLNESSES YOU HAVE	E HAD.					
LIST AND GIVE DATES OF ANY OPERATION(S) OR HO	SPITALIZATION	NS YOU HAY	/E HAD.			
LIST ANY PHYSICAL DISABILITIES THAT MIGHT HINDER	R YOUR COLLE	GE EXPERIE	NCE.			
HAVE YOU EVER HAD AN ALLERGIC REACTION TO AI	NY KIND OF D	RUG?	□ YES	□NC)	
IF YES, PLEASE STATE NAME OF DRUG(S)		· · · · · · · · · · · · · · · · · · ·		· · · · · · · · · · · · · · · · · · ·	····	

Medical Information (Continued)				
HAVE YOU EVER HAD AN ALLERGIC REACTION	ON TO ANY FOOD, INSECT BIT	TE, ETC?	☐ YES	□NO
IF YES, PLEASE EXPLAIN				
HAVE YOU EVER HAD A HEAD INJURY OR LO	SS OF CONSCIOUSNESS?	☐ YES	□NO	
IF YES, PLEASE GIVE THE DATE AND EXTENT _				
HAVE YOU EVER BEEN TOLD THAT YOU HAV	'E SOMETHING WRONG WITH	I YOUR HEAR	T?	□ NO
IF YES, WHAT?				
GENERAL CONDITION OF HEALTH IN YOUR	OPINION			
IS THERE ANY APPARENT REASON FOR RESTR	RICTION OF ACTIVITY?	☐ YES	□NO	
IF YES, WHY?				
PLEASE LIST ANY CURRENT MEDICATIONS YO	DU ARE TAKING AND WHY		 	
All information provided will be shared with Stude	ent Development, Resident Directors, Resi	sident Assistants an	d other faculty and	staff as needed
Family Contact Information				
PARENT / GUARDIAN				
ADDRESS				
PHONE ()				
ARE YOU PRESENTLY COVERED BY HEALTH II	NSURANCE?	tach copy of hec	ılth insurance car	d) □ NO
IF YES, WHAT COMPANY?		PHONI	≣#	
PRIMARY INSURED				
EMERGENCY CONTACT	PHONE #		PHONE #	
(PARENT / GUARDIAN NAME) EMERGENCY CONTACT				(WORK OR CELL)
(PARENT / GUARDIAN NAME)	(HOM			
PREFERENCE FOR EMERGENCY TREATMENT:	, , , ,		□ Olmsted (Community Hospita
PRIMARY PHYSICIAN				
ADDRESS				
PHONE ()				
Release and Waiver of Liability and Indem	nity Agreement			
Please note that there are RISKS inherent in a transportation to and from these activities. Poor its representatives responsible or liable for	articipants in these programs 8	& activities wil	I not hold Cro	ssroads College,
STUDENT'S SIGNATURE			DATE	
SIGNATURE OF PARENT/GUARDIAN	(Necessary only for students under the age	of 18)		
	(1 Tocessary only for students under the age	J. 10)		

By signing this form, you are giving permission for emergency medical treatment in the event of an injury.