RANKEN
TECHNICAL COLLEGE

RESIDENTIAL LIFE

RESIDENT MEDICAL HISTORY FORM

Name_____

Home Address _____ City, State, Zip _____

Cell Phone _____ Home Phone _____ Date of Birth_____

Gender Identification: ☐ Male ☐ Female ☐ Other_____

Emergency Contact _____

Full Address (if different from above) _____

Emergency Contact Cell Phone _____ Emergency Contact Home Phone_____

Your Physician's Name and Phone Number _____

Are you allergic to any medication or food? Yes ☐ No ☐ If yes, please list. _____
_____

Please list any other kinds of allergies, disorders, conditions and/or prescribed medications you feel necessary for Residential Life staff to know about.

_____
_____
_____

If you are currently being treated for any mental health conditions, would you like to receive information to meet with the on-campus counselor as a resource? Yes ☐ No ☐

If you have a physical or learning disability or need for academic accommodations, would you like to receive information for assistance through the Student Success Center? Yes ☐ No ☐

OPERATIVE PERMIT (FOR STUDENTS UNDER 18 YEARS OLD)

The law requires that parental permission be obtained for operative procedures on minors. A minor is defined as a person under the age of 18 years. The following consent form should be signed by the parent or guardian of the minor so that in the event of an emergency, medical procedures may be promptly carried out, and so that no unnecessary delays will occur with less urgent operative procedures. However, no operation other than minor office procedures will be performed, except in cases of extreme emergency, without the parent or guardian being contacted and fully informed. Ranken will not be held financially responsible for any operative procedures that the student may undergo.

I give permission for such operative procedures as may be deemed necessary for my son/daughter/ward.

PRINT NAME	SIGNATURE	RELATIONSHIP	DATE

RANKEN
TECHNICAL COLLEGE

RESIDENTIAL LIFE

RESIDENT IMMUNIZATION FORM

Full Name: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

IMMUNIZATION REQUIREMENTS

All students must complete the following vaccination requirements no later than 30 days after moving into the residence hall. Failure to fulfill this requirement may jeopardize your housing assignment. All students must mail or bring in a completed vaccination form, medical history form, and meningitis requirement and waiver form to the Residential Life Office.

A completed immunization form and medical history form must be returned to the Residential Life Office no later than 30 days after moving into the residence hall. Please email to reslife@ranken.edu, fax to 314-371-0241 or mail these materials to:
Director of Residential Life/Ranken Technical College/4431 Finney Avenue/St. Louis, MO 63113

MANDATORY IMMUNIZATIONS

The following immunizations are MANDATORY and must be updated or must provide documentation that you have received the required immunization.

Vaccine	Date of Immunization	Date of Immunization	Date of Immunization
Varicella (chicken pox)	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Or confirmed date of disease: ___ / ___ / ___
M.M.R. (Mumps, Measles, Rubella)	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	
Tetanus booster ***Must be administered within last 10 years.***	Dose ___ / ___ / ___	Booster type: ☐ Td ☐ Tdap	
Meningitis	Dose ___ / ___ / ___	Vaccination type: _____	
Tuberculin Skin Test ***Test must be administered within 12 months prior to entering campus housing.***	Date read: _____ Induration (mm): _____ Result: ☐ Positive ☐ Negative A positive TST requires a chest x-ray. Please include chest x-ray radiological report with this form – do not send x-rays. Please complete information below if chest x-ray is administered: Date of chest X-ray: _____ Result: ☐ Normal ☐ Abnormal		

RECOMMENDED IMMUNIZATIONS

The following immunizations are RECOMMENDED but are not required in order to live in the dormitory.

Vaccine	Date of Immunization	Date of Immunization	Date of Immunization
Hepatitis A	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Dose 3 ___ / ___ / ___
Hepatitis B	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Dose 3 ___ / ___ / ___

HEALTH CARE PROVIDER INFORMATION – Must be completed by a health care provider.

Provider Name (Print): _____ Address: _____

Provider Signature: _____ Date: _____ Phone: (_____) _____