

## HEALTH CENTER-MEDICAL HISTORY FORM

		_First Na	me:	Date of birth:	_//\$	WU ID#:
Address:				City: mail:	State:	Zip:
Cell phone #: ()			Current Er	mail:		
☐ Resident ☐ Commuter A	THLET	E: Yes_	No	Sport:		
Do you have health insurance	?	Yes	No	Please provide a copy of your ca	rd.	
PERSONAL HEALTH HIS						
This information is strictly confidential a	nd for the	use of the	Health Clinic a	nd will not be released without your knowledge	e and written cor	sent or as requested by law).
Check if you have ever had or cur	rrently h	ave any c	of the followi	ng: (note in the comments if it is a cu	rrent problem	)
	$\checkmark$	Commen	ts		$\checkmark$	Comments
ADD/ADHD	_			Head Injury		
Alcohol/Substance abuse				Heat Cramp/Heat Illness		
Anemia				Hepatitis		
Asthma				High Blood Pressure		
Bone, Joint, other deformities				Immune Disorder		
Cancer				Kidney Disorder		
Chest Pain				Meningitis		
Concussion				Mononucleosis		
Depression or Anxiety				Migraine/frequent headaches		
Diabetes				Pneumonia		
Ear, Nose, Throat Trouble				Shortness of Breath		
Eating Disorder				Stomach/Colon problems		
Epilepsy, Seizure disorder				Thyroid Disorders		
Fainting/Dizziness				TB Disease or Positive TB Test		
Heart Disease/Heart Murmur				Other		
THER INFORMATION:						
List any allergies you have (environ	mental, f	ood, media	cation, other)			
Current Medical Problems:						
Current Medical Problems:						
Current Medical Problems:						
Current Medical Problems: Routine Medications:						
Routine Medications:	ס you ha	ve chest pa	ain, trouble br	eathing or do you cough? □ yes □ no		
Routine Medications: During or after physical activity – De	-		ain, trouble br d out? □ yes			
Routine Medications: During or after physical activity – De History	ave you	ever passe	d out?   □ yes			
Routine Medications: During or after physical activity – De	ave you	ever passe	d out?   □ yes			
Routine Medications: During or after physical activity – De H Is there any other information you fe	ave you eel would	ever passe d be helpfu	d out?   □ yes			
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Routine Medications: During or after physical activity – Do Hi Is there any other information you for SMERGENCY CONTACT INFO	ave you eel would PRMATI	ever passe d be helpfu ON	d out? □ yes I for the HealtI			
Routine Medications: During or after physical activity – De H Is there any other information you fe EMERGENCY CONTACT INFO lame:	ave you eel would RMATI	ever passe d be helpfu ON	d out? □ yes I for the Healt	□ no h Center to know? elationship:		)
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Routine Medications: During or after physical activity – De Halls there any other information you for EMERGENCY CONTACT INFO Jame: Jome Phone: () CONSENT FOR TREATMENT:	ave you eel would PRMATI	ever passe d be helpfu ON	d out? □ yes I for the Healt R Work Pho	no h Center to know? elationship:	phone: (	)
Routine Medications: During or after physical activity – Do H Is there any other information you fe EMERGENCY CONTACT INFO Jame: Jome Phone: () CONSENT FOR TREATMENT: give consent for medical services and p	ave you eel would RMATI	ever passe d be helpfu ON es, immuniz	d out? □ yes I for the Healtd R Work Pho ations, medicat	□ no h Center to know? elationship:	phone: (	)

NAME:	

## Immunization Information

You may obtain your immunizations from any of the following: <ul> <li>High School Records</li> <li>Personal Shot record</li> <li>Local Health Department</li> <li>Military Records</li> <li>Previous College or University</li> </ul> Required Immunizations:         1. MMR (Measles, Mumps, Rubella): Proof of TWO DOSES, unless you were born before 1957.         Dose 1 – given at age 12 months of age or later	Must be completed by a Medical Professional or attach a copy of an official Immunization record.
Personal Shot record Local Health Department Military Records Previous College or University Required Immunizations: 1. MMR (Measles, Mumps, Rubella): Proof of TWO DOSES, unless you were born before 1957. Dose 1 – given at age 12 months of age or later	You may obtain your immunizations from any of the following:
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	Previous College or University
Dose 1 – given at age 12 months of age or later	Required Immunizations:
Dose 2 - given at age 4-6 or later, and at least one month after the first dose#2//         OR         Laboratory/serologic evidence of Immunity (attach copy of titer and date).         2. Tetanus-Diphtheria: Booster with Tdap in the last 10 years/	1. MMR (Measles, Mumps, Rubella): Proof of TWO DOSES, unless you were born before 1957.
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3. Meningitis Vaccine – <u>Highly RECOMMENDED for all students; however ALL STUDENTS MUST READ INFORMATION</u> BELOW. THE VACCINE IS REQUIRED FOR RESIDENT STUDENTSCHECK ONE OF THE THREE BOXES, THEN SIGN AND DATE! Meningococcal meningitis is an infection of the brain and it's covering layers. It may cause death or permanent disability. College freshman, especially those who live in residence halls are at moderately great risk for this infection. This form of meningitis is passes from person to person by close contact. There is an immunization available that affords substantial protection against this disease. The vaccines available protect for a minimum of 3-5 years. Additional information is available at http://www.cdc.gov Vaccine administeredDate of administration/ OR I decline receipt of the vaccine for meningococcal meningitis because I will be a commuter student. If at any time I decide to move in to the residence hall I understand I am required to have the Meningitis Vaccine. Student signature: <b>RECOMMENDED Immunizations:</b> 1. Hepatitis B (If you have had series please complete dates below.) 1/ 2/ 3/ 3. Gardasil HPV (Human Papillomavirus) 1/ 2/ 3/ 4. Hepatitis A 1/ 2/ 3/	Laboratory/serologic evidence of Immunity (attach copy of titer and date).
BELOW. THE VACCINE IS REQUIRED FOR RESIDENT STUDENTS. CHECK ONE OF THE THREE BOXES, THEN SIGN AND DATE!         Meningococcal meningitis is an infection of the brain and it's covering layers. It may cause death or permanent disability.         College freshman, especially those who live in residence halls are at moderately great risk for this infection. This form of meningitis is passes from person to person by close contact. There is an immunization available that affords substantial protection against this disease. The vaccines available protect for a minimum of 3-5 years. Additional information is available at http://www.cdc.gov         Vaccine administered.       Date of administration/ OR         I decline receipt of the vaccine for meningococcal meningitis because I will be a commuter student. If at any time I decide to move in to the residence hall I understand I am required to have the Meningitis Vaccine.         Student signature:	2. Tetanus-Diphtheria: Booster with Tdap in the last 10 years
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1/	
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Print Name:	Signature:	Date	- 1	