

MI

Name _____ Age _____ Date of Birth _____ Sex: M F
(print) Last First Middle

Social Security Number _____ Marital Status: S M D No. of Children _____

_____ Phone (____) _____
Address City State Zip

In an emergency contact: name/relationship: _____

Address _____ Phone (____) _____

• Please attach a photocopy of the front and back of insurance card to this completed health form.

Name of Insurance Company _____ Address for Claims _____ City, State _____ Zip _____

Name of Employer, if provider of insurance _____ City, State _____ Zip _____

Name of Policy Holder _____ Policy Holder's Birthdate _____ Soc. Sec. No. of Policy Holder _____ Relationship _____

Policy Number _____ Group Number _____

- Students born after 1/1/57 must attach photocopies of their immunization records to this form.
- Documentation may include: high school records, clinic records, baby book records or military records.
- Students who fail to provide the required proof of immunizations during the first semester of admission will not be allowed to register for any following semesters until they are in compliance.

First Name

(Print) Last Name

REQUIRED

MMR (measles, mumps, rubella) #1 _____ #2 _____
month year month year

First MMR must be after the age of 12 months.

OR
 Measles (rubeola) #1 _____ #2 _____ **OR** Rubeola titer result _____
month year month year

First measles (rubeola) must be after the age of 12 months.

Tuberculin Skin Test:
 Date: _____
 Result: _____
Required for International Students and any student assessed to be at risk.

RECOMMENDED

Mumps #1 _____ Rubella #1 _____
month year month year

Date of last dose of the following: DPT (diphtheria, pertussis, tetanus) _____ Tetanus _____ Polio _____
month year month year month year

Dates of Hepatitis B series: #1 _____ #2 _____ #3 _____
month year month year month year

Hepatitis A Vaccine: #1 _____ #2 _____
month year month year

Meningitis Vaccine _____ Varicella Vaccine #1 _____ #2 _____
month year month year month year

List any significant family health history; special needs you have; or prescription medication you take: _____

Allergies/ Medical Conditions	Check off or list below	Place an x for those which apply to YOU	Do you have a history of:
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Urinary tract infection
	<input type="checkbox"/> Hay fever	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Anemia
	<input type="checkbox"/> Eczema	<input type="checkbox"/> Glasses/Contacts	<input type="checkbox"/> Rheumatic fever
	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Difficult sleeping	<input type="checkbox"/> Mononucleosis
	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Eating problems	<input type="checkbox"/> Severe injury
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Headaches	<input type="checkbox"/> Drug/Alcohol dependency
		<input type="checkbox"/> Depression	
		<input type="checkbox"/> Menstrual disorder	
		<input type="checkbox"/> Worry or Nervousness	
		<input type="checkbox"/> Heart murmur	
		<input type="checkbox"/> Back problems	
		<input type="checkbox"/> Skin problems	
		<input type="checkbox"/> Scoliosis	
		<input type="checkbox"/> Hearing loss	

I authorize Student Health and/or Providence Medical Center to treat any health problems that I seek treatment for and to release medical information necessary to process insurance claims for benefits. (After 7 years this medical record is shredded.)

Student's Signature (if under 19, student and parent/guardian must sign.) _____ Date _____ Parent's/Guardian's Signature _____

PLEASE, if you have a potentially serious medical or mental condition:

1. Use this section to describe any serious medical or mental conditions, medications and medical recommendations.
2. Make an appointment to discuss the medical condition with the campus nurse, 375-7470.
3. Tell those close to you what to do in the event of an emergency (roommate, instructor, resident director or resident assistant).
4. Wear Medic-Alert identification.
5. I authorize the WSC Student Health Office to place a copy of this document listing my potentially serious medical or mental condition at the Nurses Station at Providence Medical Center Hospital.

Student's Signature (if under 19, student and parent/guardian must sign.) _____ Date _____ Parent's/Guardian's Signature _____

