WIN #_____

Wilkes University Health & Wellness Services
Passan Hall - 1st Floor
84 W. South St.
Wilkes-Barre, PA 18766

Health History

Telephone - (570) 408-4734 Fax - (570) 408-7873

The primary purpose of this form is to assure that immunizations are current and to provide a historical basis for the provision of health care through the Student Health Service. The information is **CONFIDENTIAL** and will not be released without student's written consent and will not affect admission status.

Please complete this portion before going to your physician for examination.

_____
LAST NAME (print) FIRST MIDDLE

_____
HOME ADDRESS (No. & Street) CITY or TOWN STATE ZIP CODE

_____
HOME TELEPHONE NO. STUDENT CELL PHONE NO. SOCIAL SECURITY NO.

_____
SEX DATE OF BIRTH MARITAL STATUS

EMERGENCY INFORMATION:

NAME_____RELATIONSHIP_____

ADDRESS_____

CELL PHONE_____HOME PHONE_____

ACCIDENT AND/OR HEALTH INSURANCE:

- The University requires proof of insurance coverage by each student prior to the start of the academic year.
- If a student is unable to obtain medical coverage through other means, they will be REQUIRED to participate in the university's Student Accident and Illness Program.
- Check with your insurance carrier to see if you need to make any special provisions for using your insurance coverage in our area.

- ***An annual premium will be directly charged to the students account if proof of insurance is not provided.***

PLEASE COPY BOTH SIDES OF YOUR INSURANCE CARD AND RETURN WITH THE HEALTH FORM

PERSONAL MEDICAL HISTORY

Are you being treated for any medical condition? Yes___ No___
Specify:_____

Have you ever had surgery? Yes___ No___
Specify:_____

Do you have or have ever been told that you have a heart condition? Yes___ No___
Specify:_____

Have you ever had a head injury with a loss of consciousness? Yes___ No___
Date:_____ Was a CAT scan done?_____

Have you ever felt breathlessness during physical exercise? Yes___ No___

Have you ever had chest pain or palpitations during physical activity? Yes___ No___

Do you ever feel extreme fatigue after or during exercise? Yes___ No___

Have you ever blacked out for an unknown reason? Yes___ No___

Are you **ALLERGIC** to **ANYTHING** - including prescription medications, over the counter medications, foods, insects, inhalants? Please specify allergy or reaction.

Allergic to:_____

Reaction: _____

CONFIDENTIALITY:

As a consumer of our services, confidentiality is your right, except where limited by the ethics of our practice and the law. Should you choose to have information released about you to a third party, this will be done only with your consent. Please sign to verify acknowledgement of this information.

Student Signature_____Date_____

AUTHORIZATION FOR TREATMENT:

I hereby authorize the Wilkes University Health Services to treat any illness or injury as deemed necessary by the staff. In the case of a serious medical emergency, please be advised that the student will be transported to the nearest health care facility. During a medical emergency, every effort will be made to notify the contact person listed on the health history form. All bills incurred will be the responsibility of the student.

Student Signature_____Date_____

If involved in intercollegiate sports, can this form be use as part of your physical exam? Yes__No__

Student Signature_____Date_____

Physical Examination

This section is to be completed by physician/clinician.

_____

LAST NAME (print) FIRST MIDDLE SEX

Blood Pressure_____/_____ Pulse_____ Height_____Weight _____

SYSTEMS REVIEW

Abnormalities	Normal	Abnormal	Describe
Skin	_____	_____	_____
HEENT	_____	_____	_____
Lymph Nodes	_____	_____	_____
Neck	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Back	_____	_____	_____
Breasts	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (Male)	_____	_____	_____
Pelvic (Female)	_____	_____	_____
Rectal	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neuro/Psych	_____	_____	_____

Is the patient on any medications? Please list_____

_____

Does the patient have any known allergies? Please List _____

_____

Recommendations for physical activity (college sports, PE, Intramurals, ROTC)

Unlimited_____ Limited_____

Explain:_____

Is this patient now under treatment for any medical condition?_____

_____

Is this patient now under treatment for any emotional condition?_____

Do you have any recommendations regarding the care of this patient?_____

_____

continues on back...

IMMUNIZATION RECORD

NAME____

Last First M.I.

Date of Birth_________________________________ SS#______________________________

Month/Day/Year

REQUIRED IMMUNIZATIONS

MUST BE UPDATED AS SPECIFIED BELOW

To be completed by a Health Care provider (Dates must include month and year.)

Tetanus Toxoid Diphtheria & Acellular Pertussis Vaccine (TDAP) (within 10 years) _______________

Varicella – Dose 1 ________________________Dose 2 ________________________________

Polio (year of basic series) ____

Measles/Mumps/Rubella 1st dose__________________2nd dose____________________________

Mantoux test (within year) Date___________________ Result______________________________

If Mantoux positive - chest X-ray results required

Hepatitis B Series__________________ _____________________ ______________________

PA State law requires that college students be advised of the risks associated with meningococcal disease and the availability/effectiveness of the vaccine www.cdc.gov/meningitis/index.html. All students living in university owned housing must provide proof of vaccination or a written waiver before occupancy will be permitted.

Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: the first dose at 11 or 12 years of age, with a booster dose at age 16. If the first dose (or series) is given between 13 and 15 years of age, the booster should be given between 16 and 18. If the first dose (or series) is given after the 16th birthday, a booster is not needed.

Student will be living in university owned housing Yes_____ No_____

Meningococcal Vaccine Dose 1 ______________________Dose 2 ____________________

HEALTH CARE PROVIDER

Print Name___________________________Signature__________________________Date_________

Address____

Telephone:(____)-_____________________________Fax:(____)-______________________________

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Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of the vaccination and has decided not to receive the vaccination. At this time, the student **waives** receipt of meningococcal vaccine.

Reason____

Student Signature______________________________________Date______________________