WILKES EMAIL - _____WIN #_____

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

Health History
Telephone - (570) 408-4730 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. 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 as of the 2013-14 academic year will require **all** resident students and athletes to have some form of health insurance and a **COMPLETED** health form before they are able to have access to university owned housing.

- The University requires **proof of insurance coverage** by each student prior to the start of the academic year. Please copy both sides of your insurance card and include in the envelope with the heath form.

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?_____

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_____

With my signature, I agree to have my information submitted to insurance for payment:

Student Signature _____Date _____

If involved in **Intercollegiate Sports**, can this form be used 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

	Normal	Abnormal	Describe
Abnormalities			
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 _____Had disease date _____

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 _____

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_____

HEALTH CARE PROVIDER

Print Name_____Signature_____Date_____

Address_____

Telephone:(____)-_____Fax:(____)-_____