

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 health 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\_\_\_\_\_

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.

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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](http://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:(\_\_\_\_)-\_\_\_\_\_