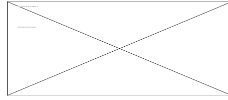
 **WIN #______________**

Wilkes University
Health 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________________________________TELEPHONE NO.________________________

ADDRESS____

RELATIONSHIP____

ACCIDENT AND/OR HEALTH INSURANCE:

As of August, 2005, Wilkes University is requiring 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. 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

*DO YOU NEED A REFERRAL?____

***CHECK WITH YOUR INSURANCE TO SEE IF YOU NEED TO MAKE ANY SPECIAL PROVISIONS FOR USING YOUR INSURANCE OUT OF YOUR CARRIERS AREA**

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 with your consent only. Please sign to verify knowledge of this information.

Student Signature____Date___________________

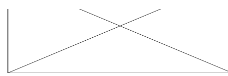
AUTHORIZATION FOR TREATMENT:

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

	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?________________

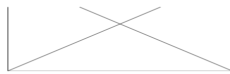
____

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.)

Diphtheria Tetanus Toxoid (within 10 years) _______________________________________

Varicella ____

Polio (year of basic series) ____

Measles/Mumps/Rubella 1st dose________________ 2nd dose________________________

Mantoux test (every year) Date____________________ Result________________________
and/or
chest X-ray__________________________

Hepatitis B Series________________ ___________________ ____________________

••

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

Student will be living in university owned housing.

Menactra™ -A/C/Y/W-135 (Meningococcal Vaccine)________________

Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of vaccination and has decided not to receive the vaccination.

Reason____

____

HEALTH CARE PROVIDER

Print Name____

Signature_______________________________________ Date________________________

Address____

Telephone:(____)-___________________________Fax:(____)-________________________