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WILKES UNIVERSITY

**Health Services
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? _____

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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) _____

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:(____)-____-____