SOUTHERN WESLEYAN UNIVERSITY

HEALTH CENTER-MEDICAL HISTORY FORM

Last Name: _____ **First Name:** _____ **Date of birth:** ___/____/___ **SWU ID#:**_____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Cell phone #: (_____) _____ **Current Email:** _____

☐ **Resident** ☐ **Commuter** **ATHLETE: Yes** ____ **No** ____ **Sport:** _____

Do you have health insurance? _____ **Yes** _____ **No** **Please provide a copy of your card.**

PERSONAL HEALTH HISTORY

(This information is strictly confidential and for the use of the Health Clinic and will not be released without your knowledge and written consent or as requested by law).

Check if you have ever had or currently have any of the following: (note in the comments if it is a current problem)

	√	Comments		√	Comments
ADD/ADHD			Head Injury		
Alcohol/Substance abuse			Heat Cramp/Heat Illness		
Anemia			Hepatitis		
Asthma			High Blood Pressure		
Bone, Joint, other deformities			Immune Disorder		
Cancer			Kidney Disorder		
Chest Pain			Meningitis		
Concussion			Mononucleosis		
Depression or Anxiety			Migraine/frequent headaches		
Diabetes			Pneumonia		
Ear, Nose, Throat Trouble			Shortness of Breath		
Eating Disorder			Stomach/Colon problems		
Epilepsy, Seizure disorder			Thyroid Disorders		
Fainting/Dizziness			TB Disease or Positive TB Test		
Heart Disease/Heart Murmur			Other		

OTHER INFORMATION:

List any allergies you have (environmental, food, medication, other)
Current Medical Problems:
Routine Medications:
During or after physical activity – Do you have chest pain, trouble breathing or do you cough? □ yes □ no **Have you ever passed out? □ yes □ no**
Is there any other information you feel would be helpful for the Health Center to know?

EMERGENCY CONTACT INFORMATION

Name: _____Relationship:_____

Home Phone: (_____) _____Work Phone: (_____) _____Cell phone: (_____) _____

CONSENT FOR TREATMENT:

I give consent for medical services and procedures, immunizations, medication and other services as needed at the SWU health center.

Student Signature: _____ _____Date: _____

Parent Signature: _____ Date: _____

(MUST be signed by parent if student is under 18 years of age)

NAME: _____ DOB: ___/____/____

Immunization Information

Must be completed by a Medical Professional or attach a copy of an official Immunization record.

You may obtain your immunizations from any of the following:

- High School Records
- Personal Shot record
- Local Health Department
- Military Records
- Previous College or University

Required Immunizations:

1. **MMR (Measles, Mumps, Rubella):** Proof of TWO DOSES, unless you were born before 1957.

☐ **Dose 1** – given at age 12 months of age or later ……#1 ____/____/____

☐ **Dose 2** – given at age 4-6 or later, and at least one month after the first dose……...#2____/____/____

OR

☐ **Laboratory/serologic evidence of Immunity** (attach copy of titer and date).

2. **Tetanus-Diphtheria**: Booster with Tdap in the last 10 years……..……____/____/____

3. **Meningitis Vaccine** – **Highly RECOMMENDED for all students; however ALL STUDENTS MUST READ INFORMATION BELOW. THE VACCINE IS REQUIRED FOR RESIDENT STUDENTS.** CHECK ONE OF THE THREE BOXES, THEN SIGN AND DATE!

Meningococcal meningitis is an infection of the brain and it's covering layers. It may cause death or permanent disability. College freshman, especially those who live in residence halls are at moderately great risk for this infection. This form of meningitis is passes from person to person by close contact. There is an immunization available that affords substantial protection against this disease. The vaccines available protect for a minimum of 3-5 years. Additional information is available at http:www.cdc.gov

☐ Vaccine administered……Date of administration ____/_____/____ OR

☐ I decline receipt of the vaccine for meningococcal meningitis because I will be a commuter student. If at any time I decide to move in to the residence hall I understand I am required to have the Meningitis Vaccine.

Student signature: _____

RECOMMENDED Immunizations:

1. **Hepatitis B** (If you have had series please complete dates below.)
   1. ___/___/___ 2. ___/___/___ 3. ___/___/___
2. **Varivax** (Varicella Vaccine)
   ☐ Had disease or vaccine 1. ___/___/___ 2. ___/___/___
3. **Gardasil HPV** (Human Papillomavirus)
   1. ___/___/___ 2. ___/___/___ 3. ___/___/___
4. **Hepatitis A**
   1. ___/___/___

HEALTH CARE PROVIDER SIGNATURE or copies of official immunization records. Verification of immunization dates.

Print Name: _____ **Signature:** _____**Date** ____**/**_____**/**_____