Wabash College
Student Health Center
P.O. Box 352
Crawfordsville, IN 47933
Voice 765-361-6265 • Fax 765-361-6269

Student Health Record

Intended enrollment date: _____

Instructions to Student

1. Answer all questions using black ink or a typewriter. This information is for the use of the medical staff of the Student Health Center and the Wabash Athletic Department. It may be released for purposes of medical treatment, payment or health care operations of the Wabash Student Health Center or Athletic Department.
2. Present this form to your family physician or other licensed physician or nurse and request that he/she review the information and verify your immunizations status.
3. This form is **mandatory** for all students and must be returned to Wabash College by July 16, 2008. Please note that you **will not be allowed to register for classes** if we do not have an up-to-date immunization record. Immunizations may only be waived for religious reasons by providing us a letter from the leader of your organization on its letterhead.

Personal Data

Citizenship: U.S. ☐ Other: ☐ _____ Marital status (circle): M S W D

Social Security Number: _____ Your Cell Phone Number: _____

Full Name: _____ Date of birth: _____
Last First Middle

Home Address: _____ City _____ State _____ Zip _____

Notify in case of emergency _____ Relationship _____

Address: _____ Phone: ( ) _____ Cell: ( )_____

Personal physician: _____ Telephone: ( ) _____ Fax: ( ) _____

Address: _____

To be signed by a parent or legal guardian if the student is under 18 years of age.

I hereby authorize the Wabash College physicians, nurse, and athletic trainer to examine and/or treat for minor injury or illness and when considered necessary, to make a referral to an appropriate medical facility or another treating physician. I also consent to emergency treatment or procedures by a licensed physician if deemed necessary.

Signature: _____ Relationship (if guardian): _____

Telephone if guardian: ( ) _____

Insurance Information
(Attach Copy of Insurance Card)

Insurance Company: _____ Is it an HMO? Yes No

Name of insured: _____ Check if not covered by parental insurance ___

Identification (Group and/or policy) numbers: _____

Relationship of insured to student: _____

Student Name: _____

Immunization Record

REQUIRED

A. Diptheria-Pertussis-Tetanus
   Series completed _____ (mo/year)
   Booster within last 10 yrs _____ (mo/year)
B. MMR (Measles, Mumps, Rubella)
   At 12 mos or before 5 yrs: _____ (mo/year)
   Booster at age 5 or later: _____ (mo/year)
   If received MMR, skip C,D,E
C. Rubeola
   Confirmed Disease: _____ (mo/year)
   Live vaccine: _____ (mo/year)
D. Rubella
   Confirmed Disease: _____ (mo/year)
   Vaccine: _____ (mo/year)
   Immune titer: _____ (mo/year)
E. Mumps
   Confirmed Disease: _____ (mo/year)
   Vaccine: _____ (mo/year)
F. Polio
   Type of vaccine ☐ oral ☐ inactivated
   Completed series: _____ (mo/year)
   Booster _____ (mo/year)

Required for foreign students or students exposed to tuberculosis (TB)

G. Tuberculosis
   PPD (mantoux) test within past year (even if received bCG vaccine)
   Result: ____ mm induration Date: _____
   Chest X-ray for positive: Date: _____
   Results: _____
   bCG vaccine administered: _____ (mo/year)

OPTIONAL VACCINES

H. Hepatitis B (strongly recommended)
   Dates of series: _____ _____ _____
I. Meningococcal Vaccine: _____ (mo/year)
J. Varicella (chickenpox) - recommended
   Confirmed disease or titer: _____ (mo/year)
   Vaccine completed
   (2 doses over age 13): _____ (mo/year)

I certify that the above immunization information is correct to the best of my knowledge (physician or licensed nurse)

_____ _____
Signature Date

Personal Medical History

Medications you are taking (include vitamins, herbs, etc.): _____
_____

Medication allergies: _____
_____

Surgeries: _____

Past History (check if you have had any of the following in the past):

☐ Mononucleosis
☐ Rheumatic Fever
☐ Diabetes
☐ Eye problems
☐ Ear/nose/throat disease
☐ Endocrine/thyroid disease
☐ Emotional problems
☐ Head injury
☐ Seizures
☐ Chest disease/asthma
☐ Heart disease
☐ Hypertension
☐ Anemia
☐ Gastrointestinal disease
☐ Jaundice
☐ Kidney/bladder disease
☐ Sexually transmitted disease
☐ Back/joint problems
☐ Cancer/tumor/cyst
☐ Physical handicap
☐ Skin disease
☐ Serious illness/accident
☐ Eating disorder
☐ Substance abuse
☐ Smoking
☐ Alcohol abuse

Space for notes on past history

Student Name: _____

Family History

	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brothers/ Sisters				

Have any of your relatives ever had any of the following?:

	Yes	Relationship
Tuberculosis		
Diabetes		
Hypertension		
Heart disease		
Arthritis		
Hay fever		
Cancer		

ATTESTATION

Medical information withheld, incomplete or incorrect relieves Wabash College and its agents from all medical or legal liability and may disqualify you from participation in athletics or club sports. The information given on this form is correct to the best of my knowledge. I give permission for this information to be shared, when necessary for my treatment, payment for services or for health care operations of the Wabash College Student Health Center and the Wabash College Athletic Department.

_____ _____
Signature if student over 18 Date

_____ _____ _____
Parent/guardian signature if under 18 Relationship Date

Record any additional details/information below: