

THE COLLEGE OF
WOOSTER

DATE _____

DATE of BIRTH ____ / ____ / ____

SEX: Male Female

REPORT OF MEDICAL HEALTH

A Message Concerning Your Health:

It is the aim of The College of Wooster to have each student enjoy as complete an experience as his or her physical and mental health will permit. Your medical history will provide the essential information needed to meet that goal. The history is required primarily to determine what special arrangements or services, if any, are necessary to meet the individual needs of a student. Please note that use of this form makes it unnecessary for you to submit a physician's physical examination report. It is most important, therefore, that you complete this questionnaire fully and accurately.

The Longbrake Student Wellness Center urges correction of remediable physical defects, including dental and visual, prior to arrival on the campus. Immunization and vaccinations against rubeola, rubella, mumps, tetanus, poliomyelitis, diphtheria, and others as your own physician may advise are required before arrival at Wooster.

LAST NAME (Print)	FIRST NAME	MIDDLE	SOCIAL SECURITY NO.	
HOME ADDRESS (Number and Street)	CITY OR TOWN	STATE	ZIP CODE	CELL PHONE NUMBER
NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN		HOME PHONE NUMBER	CELL PHONE NUMBER	
EMERGENCY CONTACT AND ADDRESS (OTHER THAN THE ABOVE) - REQUIRED			EMERGENCY TELEPHONE (OTHER THAN THE ABOVE) - REQUIRED	
LIST OF COLLEGES YOU HAVE ATTENDED, ADDRESSES, AND DATES				CITIZENSHIP
S <input type="checkbox"/> M <input type="checkbox"/> OTHER <input type="checkbox"/>				
ARE YOU A VETERAN? BRANCH AND LENGTH OF SERVICE		MARITAL STATUS	CLASS YOU ARE ENTERING	

FAMILY HISTORY

I AM ADOPTED AND DON'T KNOW MY FAMILY HEALTH HISTORY.

	Age	State of Health	Occupation	Age at Death	Cause of Death	Have any of your relatives had any of the following?		Relationship	
						Yes	No		
FATHER						Tuberculosis			
MOTHER						Diabetes			
BROTHERS						Kidney Disease			
						Heart Disease			
						Arthritis			
						Stomach Disease			
SISTERS						Asthma, Hay Fever			
						Epilepsy, Convulsions			
						Stroke			
						High Blood Pressure			
						Cancer (type)			

STATEMENT OF AUTHORIZATION

I authorize and request The College of Wooster Longbrake Student Wellness Center to administer out-patient and in-patient, medical, surgical services and immunizations and to perform emergency procedures, as necessary, or to refer to duly licensed medical personnel when indicated, including transfer to outside hospitals.

I authorize any physician, practitioner, clinic, or hospital to furnish to The College of Wooster Longbrake Student Wellness Center all information concerning my case history and the treatment, examinations or hospitalization which I received in the past, including copies of hospital and medical records for the purpose of my treatment, diagnosis or other medical care while at The College of Wooster.

I also authorize the release of my Social Security Number for medical and/or insurance purposes while at The College of Wooster. I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural, and intercollegiate athletics unless otherwise noted in this Student Health Information Form. I authorize employees of the Longbrake Student Wellness Center to disclose as necessary, under the governing laws of FERPA, health information to other departments at The College of Wooster.

Signature of Student

Signature of Parent or Guardian. (If under legal age 18 of adulthood in Ohio.)

Date

Date

IMMUNIZATIONS:

REQUIRED:	MONTH / DAY / YEAR OF INJECTIONS
MMR (2 dates required – measles, mumps, rubella)	1st 2nd
Hepatitis B (3 dates required unless waiver signed for housing)	1st 2nd 3rd
Meningococcal Meningitis (date required unless waiver signed for housing)	1st
RECOMMENDED:	
Tetanus (date of DT, TDAP, or DPT within past 10 years)	1st
Polio	1st 2nd 3rd 4th 5th
Chicken Pox Vaccine (if haven't had disease)	1st 2nd
OTHER IMMUNIZATIONS:	
Hepatitis A (2 doses)	1st 2nd
HPV (Gardasil, 3 doses 0, 2, 6 months)	1st 2nd 3rd
TB Test (PPD) and Results	
Other	

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below. Indicate age of onset for all YES answers. Attach additional sheet if necessary. **If you have a significant health problem please attach record from home physician.**

HAVE YOU HAD:	YES	DATE	NO	HAVE YOU HAD:	YES	DATE	NO	HAVE YOU HAD:	YES	DATE	NO
Measles				High Blood Pressure				Thyroid trouble			
German Measles				Skin Disorder				Learning Disability			
Mumps				Stomach/Intestinal Trouble				Attention Deficit Disorder			
Chickenpox				Kidney/Bladder Disease				Dyslexia			
Frequent Colds				Back Problems				Frequent UTI			
Malaria				Injury/Disease of Joint				Surgery:			
Meningitis				Anemia				Appendectomy			
Mononucleosis				Difficulty Sleeping				Tonsillectomy			
Sinusitis				Frequent Anxiety				Other (List)			
Rheumatic Fever				Frequent Depression				Allergy:			
Scarlet Fever				Worry/Nervousness				Drugs (List)			
Tuberculosis				Recurrent Headache				Foods (List)			
Tumor, Cancer, Cyst				Head Injury/Concussion (with unconsciousness)				Other (List)			
EENT Trouble				Epilepsy (seizure)				Hearing Loss			
Hay Fever				Paralysis, weakness				Loss or seriously impaired function of any organ			
Asthma				Eating Disorder (Anorexia, Bulimia)							
Pneumonia				Diabetes							
Heart Disease											

	YES	NO
Other than routine physicals, have you consulted, been treated, or been counseled by a physician, clinics, or other practitioners in the past 2 years?		
Have you ever had any serious illness, injury or been hospitalized other than already noted? Give details.		
If you are currently receiving allergy shots, do you plan to continue them at The College of Wooster?		
Has your physical activity been restricted in the past 2 years? Give reasons and duration.		
Are you a vegetarian or on a restricted diet? What type?		

	YES	NO
Have you received treatment/counseling for mental health-related issues?		
Are you currently receiving counseling?		
Do you plan to continue counseling while at The College of Wooster?		
Do you use glasses or contacts? If yes, bring spare glasses.		
Are you now using any medications? Please list all medications and dosage.		
Do you use a medically-required device? Please list.		

GENERAL INFORMATION: We would be interested in knowing if you are currently trained as: EMT First Responder CPR