THE COLLEGE OF
WOOSTER

## STUDENT HEALTH INFORMATION FORM

**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_____ First Name _____ Middle Name _____

Date of Birth _____ SS# _____

Gender: ☐ Male ☐ Female ☐ Transgender Are you a transfer student? ☐Yes ☐No Married: ☐Yes ☐No

Home Address_____
Street City State Zip

Home Phone Number_____ Student Cell Phone Number _____

Emergency Contact #1: Name/Relationship _____ Phone # _____

Emergency Contact #2: Name/Relationship _____Phone # _____

| **Family History** | Age | Occupation | State of Health | If Deceased, Cause | Age | Have any of your relatives had any of the following? If Yes / Relationship | |
|---|---|---|---|---|---|---|---|
| Parent 1 | | | | | | Tuberculosis | |
| Parent 2 | | | | | | Diabetes | |
| Brother (s) | | | | | | Kidney Disease | |
| | | | | | | Heart Disease | |
| | | | | | | Hereditary Disease | |
| Sister (s) | | | | | | Psychiatric Illness | |
| | | | | | | Epilepsy, Seizure | |
| | | | | | | Alcohol/Drug | |
| | | | | | | Cancer (type) | |
| ☐ I AM ADOPTED AND DON'T KNOW MY FAMILY HISTORY. | | | | ☐ I AM ADOPTED AND DO KNOW MY FAMILY HISTORY. | | | |

## STATEMENT OF AUTHORIZATION

I authorize and request The College of Wooster Longbrake Student Wellness Center to administer outpatient and inpatient, 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_____ Date _____

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

## ***PROVIDE COPY OF PRIVATE INSURANCE CARD***

Longbrake Student Wellness Center • 570 E. Wayne Ave. Wooster, Ohio 44691
Telephone (330) 263-2319 • Fax (330) 263-2369 • www.wooster.edu

STUDENT NAME _____

**IMMUNIZATIONS Please provide certified immunization record. If not available, give dates below.**

| **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 | 2nd | | | |
| **RECOMMENDED:** | | | | | |
| Tetanus (date of DT, TDAP, or DPT within past 10 years) | Most Recent Tdap | Td | | | |
| 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) or Cervarix (circle) | 1st | 2nd | 3rd | | |
| TB Test (PPD) and Results | Date | Results | | | |
| Other | | | | | |

**Personal History**

*Please answer all questions. Comment on all positive answers on a separate sheet of paper. Indicate age of onset for all YES answers.* ***<u>If you have a significant health problem, please attach records from home physician.</u>***

| **HAVE YOU HAD** | **YES** | **DATE** | **NO** | **HAVE YOU HAD** | **YES** | **DATE** | **NO** | **HAVE YOU HAD** | **YES** | **DATE** | **NO** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Frequent Colds | | | | Stomach/Intestinal Trouble | | | | Learning Disability | | | |
| Loss or seriously impaired function of any organ | | | | Kidney/Bladder Disease | | | | Attention Deficit Disorder | | | |
| Meningitis | | | | Back Problems | | | | Dyslexia | | | |
| Mononucleosis | | | | Injury/Disease of Joint | | | | Malaria | | | |
| Sinusitis | | | | Anemia | | | | Frequent UTI | | | |
| Rheumatic Fever | | | | Difficulty Sleeping | | | | Heart Disease | | | |
| Scarlet Fever | | | | Frequent Anxiety | | | | Eating Disorder | | | |
| Tuberculosis | | | | Frequent Depression | | | | Diabetes | | | |
| Tumor//Cyst | | | | Worry/Nervousness | | | | High Blood Pressure | | | |
| Pneumonia | | | | Paralysis, weakness | | | | | | | |
| Ear, eye, nose, throat problems | | | | Recurrent Headache | | | | Skin Disorder | | | |
| Hay Fever | | | | Hearing Loss | | | | Thyroid Trouble | | | |
| Asthma | | | | Epilepsy (seizure) | | | | Cancer | | | |

List any **allergies** to:

**Medications** (list **type of reaction** you had):

**Food** and **environmental** allergens:

List any medications you currently take with dosage (include over the counter meds, contraceptives, and herbal drugs or supplements):

Have you ever had any serious illness, injury, surgery or been hospitalized? ☐Yes ☐No ☐ Still in treatment (If yes, give details)

_____

_____

If you are currently receiving allergy shots, do you plan to continue them at The College of Wooster? ☐Yes ☐No

Are you a vegetarian or on a restricted diet? (If yes, please list what type.) ☐Yes ☐No Type: _____

Have you received treatment/counseling for mental health related issues? ☐Yes ☐No

If yes, do you plan to continue counseling while at The College of Wooster? ☐Yes ☐No

Do you use glasses or contacts? (If yes, bring spare glasses.) ☐Yes ☐No

Do you use a medically required device? (If yes, please list.) ☐Yes ☐No _____

Head/Neck injury ☐Yes ☐No Number of head injuries? _____ Concussion? ☐Yes ☐No How many times? _____

Are you currently trained as: ☐ EMT ☐ First Responder ☐CPR

I hereby state that the information on this health form is true. I give permission for Longbrake Student Wellness Center to release my medical information to The College of Wooster Student Affairs, and to health care providers and facilities involved in my treatment.

Student's Signature_____ Date_____