

**BISHOP WELLNESS CENTER
WILLAMETTE UNIVERSITY**

PHONE: 503-370-6062

FAX: 503-375-5420

HEALTH HISTORY

LAST NAME _____	FIRST _____	MIDDLE _____	NAME OF PARENT, GUARDIAN OR SPOUSE _____
CAMPUS/LOCAL ADDRESS, IF KNOWN _____			HOME ADDRESS _____
CITY _____	STATE _____	ZIP _____	CITY _____ STATE _____ ZIP _____
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			STUDENT'S STATE OR COUNTRY OF BIRTH _____
PHONE _____	PROGRAM: _____		HEALTH INSURANCE INFORMATION: ATTACH COPY OF CARD
DATE OF BIRTH _____	AGE _____	DATE ENTERING WILLAMETTE _____	INSURANCE CARRIER _____ INSURANCE PHONE NUMBER _____
IN CASE OF EMERGENCY NOTIFY:			SUBSCRIBER NAME _____
NAME _____	RELATIONSHIP _____		SUBSCRIBER ID # _____ SUBSCRIBER DATE OF BIRTH _____
PHONE _____			

PERSONAL AND FAMILY HISTORY (check YES answers only)

	You	Family	Please explain
Asthma			
Allergies/Environmental			
Migraines			
Diabetes			
Gastrointestinal Disorder			
Hepatitis			
Anemia or Blood Condition			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Cancer			
Immunocompromising Condition			
Rheumatoid Arthritis			
Seizure Disorder			
Tuberculosis			
Head Injury/ Concussion			
Hearing Loss			
Vision Impairment			
Mobility Limitations			
Depression			
Anxiety			
Bulimia/ Eating Disorder			
ADD/ Learning Disability			
Alcohol/Drug Counseling or Treatment			

Allergies to medication _____
 Prior hospitalizations (include residential and inpatient treatment) _____
 Disability or condition that required accommodations in the past or that interferes with schoolwork _____

(To be evaluated for accommodations contact Disability and Learning Services at 503-370-6471)

Drugs/Medicines you use regularly (includes contraceptives, herbal medicine) and conditions they treat _____

Mental health and medical conditions currently under treatment _____

Women: Date of Last Pap: _____

(PLEASE TURN OVER TO COMPLETE)

IMMUNIZATIONS

Immunization records may generally be obtained from your family physician, last school attended or your parents.

MEASLES (Rubeola/ Hard Measles) VACCINATION REQUIREMENT

Each entering student born on or after January 1, 1957, must have **two doses of measles vaccine** (documented by month and year of each dose) on or after the first birthday, with a minimum of 28 days between the doses.

MEASLES or MMR Immunization date(s): **1. Month** _____ **Yr.** _____ **2. Month** _____ **Yr.** _____

Or **1st dose childhood record unavailable but given 2nd dose: Month** _____ **Year** _____
(International students need documentation of both dates)

If you fail to document compliance, you will not be allowed to complete your registration or attend classes.

AGE, MEDICAL OR RELIGIOUS EXEMPTION FOR TWO-DOSE MEASLES VACCINE

AGE EXEMPTION

I was born before 1957 and am therefore considered immune. Date of birth (month/day/year) _____

STUDENT SIGNATURE

DATE

RELIGIOUS EXEMPTION

I am an adherent to a religion whose teachings are opposed to immunization and request that I be exempted from the immunization requirement.

STUDENT SIGNATURE

DATE

MEDICAL EXEMPTION

I certify that the above-named student should be exempted from the requirements for the measles vaccine based on:

- A. History of measles (month/year) _____
- B. Immune titer shows immunity to measles (month/year) _____
- C. The following medical reason _____
constitutes a medical contraindication in accordance with the advisory committee on immunization practices of the U.S. Public Health Services for measles vaccine.

SIGNATURE OF HEALTH CARE PRACTITIONER

DATE

PRINTED NAME & TITLE OF HEALTH CARE PRACTITIONER

TELEPHONE NUMBER

MENINGOCOCCAL VACCINATION RECOMMENDATION (NOT REQUIRED)

The CDC recommends that all first year students living in residence halls be immunized against meningococcal disease, a rare but potentially fatal bacterial infection commonly referred to as meningitis. College students living in residence halls are more likely to contract meningococcal disease than the general population due to lifestyle factors such as close living situations, active or passive smoking, irregular sleep patterns and sharing personal items.

Meningococcal vaccines are available in the Health Service.

Meningococcal Immunization date: _____ Type: Conjugate (Menactra Brand) Polysaccharide (Menomune)

OTHER RECOMMENDED IMMUNIZATIONS (NOT REQUIRED)

Diphtheria, Tetanus, Pertussis (booster within last 10 years) date: _____ Type: Td Tdap

Polio Series (4 doses) dates: _____

Mumps and Rubella (within the MMR immunization-two doses) dates: _____

Hepatitis A Series: (two doses): _____

Hepatitis B Series: (three doses): _____

Gardasil Series: three doses: _____

Varicella (Chickenpox) (two doses): _____ **or History of Chickenpox infection** year: _____

Please check this box if you have not been immunized for chickenpox and have not had chickenpox

Please sign and return this form before **August 1** to:

Bishop Wellness Center
Willamette University
900 State Street
Salem, OR 97301
Phone: 503-370-6062 Fax: 503-375-5420

Student Signature

Date