



## **Student Health Services**

To: Incoming Residential Students  
From: Student Health Services  
Subject: Student Immunization and Medical History Form

This is to inform you that Wright State University has adopted a "Policy on Resident Immunization." The policy requires Resident Students to present evidence of up-to-date immunizations prior to moving into a University owned or managed property.

Required immunizations are: (written documents, including dates)

1. A recent Tetanus/diphtheria (Td) booster as an adult (within 10 years).
2. Mumps, Measles, Rubella (MMR) -- two (2) doses: first inject at least 12 months after birth, and second injection prior to college arrival.

Complete the Student Immunization and Medical History Form and return to:

**Student Health Services  
051 Student Union  
3640 Colonel Glenn Hwy.  
Dayton, OH 45435-0001**

PRIOR to the first day of the Quarter. Failure to submit a completed form may result in a "HOLD" being placed upon your registration.

Thank you for your cooperation. Any questions may be answered by calling (937)775-2552, Monday through Friday 8:30 am -5:00 pm; closed for lunch from 12 noon – 1 pm. We take our last walk-in patients at 11:30 am and 4:30 pm.

Student Health Services  
 051 Student Union  
 3640 Colonel Glenn Hwy.  
 Dayton, OH 45435-0001  
 PHONE: (937) 775-2552  
 FAX: (937) 775-3260

**WRIGHT STATE UNIVERSITY  
 MEDICAL HISTORY FORM  
 RESIDENTIAL STUDENTS**

DATE: \_\_\_\_\_

UID: \_\_\_\_\_

(Print)

**NAME:** \_\_\_\_\_  
 LAST NAME FIRST NAME MIDDLE NAME

**ADDRESS** \_\_\_\_\_  
 STREET OR PO BOX CITY STATE ZIP

**DATE OF BIRTH** \_\_\_\_\_ **PLACE OF BIRTH:** \_\_\_\_\_

**GENDER** MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

LOCAL HOME PHONE NUMBER \_\_\_\_\_ CELL PHONE NUMBER \_\_\_\_\_

PERSON TO NOTIFY IN AN EMERGENCY \_\_\_\_\_ THEIR PHONE # \_\_\_\_\_

**INSURANCE INFORMATION**

NAME & ADDRESS OF INSURANCE CO \_\_\_\_\_

POLICY HOLDER'S NAME \_\_\_\_\_ POLICY # \_\_\_\_\_

ID# \_\_\_\_\_ MEMBER # \_\_\_\_\_ GROUP # \_\_\_\_\_

**ALLERGIES** TO MEDICATION \_\_\_\_\_ TO FOOD \_\_\_\_\_

**CURRENT MEDICATIONS (INCLUDING DOSAGE)** \_\_\_\_\_

Have you ever had, so do you currently have, any of the following?

	Yes	No		Yes	No		Yes	No
1. Anemia or other blood disease			5. Diabetes			9. Rheumatic Fever		
2. Asthma			6. Heart disease			10. Seizures		
3. Bone or joint disease			7. Kidney disease			11. Other (Please specify)		
4. Chickenpox			8. Lung disease					

**REQUIRED IMMUNIZATIONS – (WRITTEN DOCUMENTS REQUIRED)**

**TETANUS (TETANUS, TD, DT, TDAP)**  
 WITHIN THE PAST TEN YEARS \_\_\_\_\_  
 MONTH / DAY / YEAR

**MMR (Measles, Mumps, Rubella)**  
**TWO (2) DOES AFTER AGE ONE (1) YEAR**  
 AND MINIMUM 30 DAYS APART \_\_\_\_\_  
 MONTH / DAY / YEAR MONTH / DAY / YEAR

