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 Semester. 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.

Please note:

We take our last walk-in patients at 4:30 pm.

During breaks, we are closed for lunch, taking the last walk-in patients 11:30 am and reopening at 1pm.
WRIGHT STATE UNIVERSITY
MEDICAL HISTORY FORM
RESIDENTIAL STUDENTS

DATE: ___________________
UID#: ___________________

(Print)
NAME ____________________________________________________________
LAST NAME FIRST NAME MIDDLE NAME

ADDRESS __________________________________________________________
STREET OR P O 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 (Please include at least one of the following numbers)

NAME AND 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, or do you currently have, any of the following?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1. Anemia or other blood disease</td>
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<td>2. Asthma</td>
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<td>3. Bone or joint disease</td>
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<td>4. Chickenpox</td>
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<td>5. Diabetes</td>
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<td>6. Heart disease</td>
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<td>7. Kidney disease</td>
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<td>8. Lung disease</td>
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<td>9. Rheumatic Fever</td>
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<td>10. Seizures</td>
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<td>11. Other (please specify)</td>
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REQUIRED IMMUNIZATIONS

TETANUS (TETANUS, TD, DT, TDAP)
WITHIN THE PAST TEN YEARS _______________________ / _______ / _______
MONTH DAY YEAR

MMR (Measles, Mumps, Rubella)
TWQ (2) DOSES AFTER AGE ONE (1) YEAR AND MINIMUM 30 DAYS APART _______________________ / _______ / _______
MONTH DAY YEAR _______________________ / _______ / _______
MONTH DAY YEAR
**RECOMMENDED IMMUNIZATIONS**

HEPATITIS B (Three doses of vaccine, or Positive Hep B Surface Antibody)

<table>
<thead>
<tr>
<th>Dose #1</th>
<th>MM</th>
<th>DD</th>
<th>YY</th>
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<tbody>
<tr>
<td>Dose #2</td>
<td>MM</td>
<td>DD</td>
<td>YY</td>
</tr>
<tr>
<td>Dose #3</td>
<td>MM</td>
<td>DD</td>
<td>YY</td>
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</table>

Hepatitis B Surface Antibody

Date _________

Results _________

MENNINGITIS VACCINE

Date _________

**SIGNATURE AND CONSENT**

*(IF STUDENT IS UNDER 18 YEARS OF AGE, BOTH STUDENT AND PARENT MUST SIGN)*

I certify that the medical facts stated above are true to the best of my knowledge. I hereby consent to the performance of diagnostic procedures, including x-ray and laboratory tests, pelvic examinations, and the administration of treatments or medications that any physician or dentist associated with or consulted by Student Health Services deems necessary, and I agree to pay any charges for services not covered by university fees or by insurance.

I hereby consent to the release of medical information to the appropriate university representatives.

________________________________________
Signature of student

Date

________________________________________
Signature of parent or legal guardian

Date

if student is under 18