Wright State University
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’s "Policy on Resident Immunization" requires residential students to present evidence of up-to-date immunizations prior to moving into a University owned or managed property. For the residential student to be in compliance with this policy, it is necessary to submit the Medical History Form for Residential Students to Student Health Services.

Please note: the required immunizations are:

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

Prior to the first day of the semester, complete the Medical History Form for Residential Students and submit directly to:

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

Failure to submit a completed form will result in a "HOLD" being placed upon your registration until the completed document is received and review indicates that the required immunizations are in compliance with university policy.

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 11:30 a.m. in the morning and 4:30 p.m. in the afternoon.
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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<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)

TWO (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)

Dose #1  ____/_____/______  Dose #2  ____/_____/______  Dose #3  ____/_____/______
MM  DD  YY  MM  DD  YY  MM  DD  YY

MENNINGITIS VACCINE  Dose #1  ____/_____/______  Dose #2 (over age 16)  ____/_____/______
MM  DD  YY  MM  DD  YY

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