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 and a copy of immunization records 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.

**WRITTEN PROOF OF IMMUNIZATIONS MUST BE SUBMITTED ALONG WITH YOUR MEDICAL HISTORY FORM**

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 and immunization records 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>
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<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  **WRITTEN PROOF OF IMMUNIZATIONS MUST BE SUBMITTED WITH THIS FORM.**

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

RECOMMENDED IMMUNIZATIONS

HEPATITIS B (Three doses of vaccine)

Dose #1  ___/___/_____  Dose #2  ___/___/_____  Dose #3  ___/___/_____  
MM  DD  YY

MENINGITIS VACCINE  
Dose #1  ___/___/_____  Dose #2 (over age 16)  ___/___/_____  
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 health care professional 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