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.
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?

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<td>1. Anemia or other blood disease</td>
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<td>5. Diabetes</td>
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<td>9. Rheumatic Fever</td>
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<td>4. Chickenpox</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

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 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