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 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>
<td>5. Diabetes</td>
<td>9. Rheumatic Fever</td>
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<tr>
<td>4. Chickenpox</td>
<td>8. Lung disease</td>
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STUDENT HEALTH SERVICES
051 STUDENT UNION
3640 COLONEL GLENN HWY
DAYTON, OH 45435
PHONE (937) 775-2552
FAX (937) 775-2277
**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  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

MENINGITIS 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 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