**Note to the Student:**
Unless **ALL** required **Immunizations** and **Physical Examination** are submitted by June 1st, Fall or Dec 1 Spring, a HOLD will be placed on your student account.

# WESTFIELD STATE UNIVERSITY
# STUDENT HEALTH FORM

www.westfield.ma.edu/healthservices

**IMPORTANT**
**Upload completed health forms on WSU Health Services website.**

## SIDE 1 - TO BE FILLED OUT BY THE STUDENT

## REPORT OF MEDICAL HISTORY

**PLEASE PRINT**

Complete before going for your physical examination.

**Name: Last** **First** **M.I.** **Student ID# A…** **WSU Year of Grad** **Date of Birth**

**Gender Identity:**_____________ **Chosen Name:** _____________ **Preferred Pronouns:** _______________

**Home Address: Street** **City** **State** **Zip** **Home Phone** **Cell Phone**

**Emergency Contact: Name/Relationship** **Home Phone** **Business Phone** **Cell Phone**

**Emergency Contact: Name/Relationship** **Home Phone** **Business Phone** **Cell Phone**

**Health Insurance Carrier (if possible send copy of card)** **Policy Number** **Card Holder** **Card Holder's Birthdate**

**Emergency**: Permission is hereby granted for emergency medical treatment for my **minor**. Every effort will be made to contact Parents/Guardians.

**Signature**: ____________________________________________
Parent or Legal Guardian (if student under 18)

**MEDICAL HISTORY:**

**Drug Allergies: Yes**____ **No**____ If YES, list drug and reaction:________________________________________

**Other Allergies**: Insects, food etc.: ___________________________

**Please check applicable box below**:

| History of: | Yes | No | History of: | Yes | No | History of: | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Addiction | | | Gastrointestinal Problems | | | Strep Throat | | |
| Alcoholism | | | Head Injury (Concussion) | | | Substance Use disorder | | |
| Anemia | | | Headaches (Recurrent) | | | Surgery | | |
| Asthma | | | Hearing Deficit | | | Appendectomy | | |
| Back injury/problem | | | Heart Problems | | | Tonsillectomy | | |
| Chickenpox: Date if known | | | Hepatitis (A, B, C, D, E) | | | Other surgery-comment below | | |
| Depression/Anxiety | | | High Blood Pressure | | | Tobacco/Marijuana user | | |
| Diabetes | | | Kidney Problems | | | **Any Non-prescribed drug use** | | |
| Disease/Injury of joints/bones | | | Learning Disability | | | Tuberculosis or positive test | | |
| Ear, Nose, Throat Problems | | | Mononucleosis | | | Thyroid Disease | | |
| Eating Disorders | | | Seizures | | | Cancer: date of dx and type | | |
| Eye Problems | | | Sickle Cell Trait/Disease | | | Birth Control | | |
| Fainting | | | Skin Condition: | | | Menstrual Disorder | | |

**Have you been hospitalized for mental health concerns**? If yes, please write date/place/reason for hospitalization.

List any **daily/regular medications/birth control** and conditions for which medications are prescribed:

**Please explain any YES answers above, note ANY hospitalizations (date/reason), and any special needs below:**

Student's Signature Date

**TO THE STUDENT: This information is confidential and subject to protection under HIPAA. The University will not be liable for any medical history information that is omitted from this form.**

**SIDE 2 - TO BE FILLED OUT BY HEALTH CARE PROVIDER *or* Attach copy of Electronic Medical Record/Provider form**

Name: ______________________________________ DOB: _______________

| VACCINATIONS ✷ = *Required* | DATE Month/Year | DATE Month/Year | DATE Month/Year | DATE Month/Year | LABS- recommended Urinalysis |
|---|---|---|---|---|---|
| *Tdap (within past 10 years) | #1 | | | | Glucose: |
| *MMR Series (2 doses required) OR | #1. | #2. | | | Micro: |
| *MMR titers Please circle results and note date | 1. Measles Titer (Rubeola) Pos Neg Date: | 2. Mumps Titer Pos Neg Date: | 3. Rubella Titer Pos Neg Date: | | **Blood** Hgb. Hct. |
| *Hepatitis B Series or Titer (3 doses required) | #1. | #2. | #3. | or Hepatitis Titer Pos Neg Date: | |
| *Varicella/VAR Series or Titer- If no history of Chickenpox illness (2 doses required) | #1 | #2 | History of Chickenpox Date: | or Varicella Titer: Pos Neg Date: | |
| **Meningitis ACWY Must be given on or after 16th birthday Required for full-time students 21 years of age or younger. | #1 | #2 | Meningitis B (Recommended) | #1 | #2 #3 Bexero 2 dose series Trumenba 2 to 3 dose series |
| Covid-19 AND FLU | #1. | #2. | #3 | #4 | FLU (month/yr) |
| HPV Vaccine Series (Gardasil) | #1. | #2. | #3 | | |
| TB (PPD Skin Test/IGRA blood test) (Health Science students or If indicated by risk assessment form) | Month/Year | Neg ______mm | Pos _____mm | If PPD or IGRA is Positive, Chest X-ray report is required | |

**Students may decline MenACWY vaccine after they have read, signed and submitted the *Meningitis Information Waiver Form*.

- **PHYSICAL EXAMINATION Date:** ___________ HT: __________ WT: __________ BP: __________ Pulse: __________
- **Tb Risk level:** ___________

**SYSTEMS REVIEW**: Are there any abnormalities of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Ears, Nose or Throat | | | 7. Genitourinary | | |
| 2. Eyes | | | 8. Musculoskeletal | | |
| 3. Respiratory | | | 9. Neuropsychiatric | | |
| 4. Cardiovascular | | | 10. Metabolic/Endocrine | | |
| 5. Gastrointestinal | | | 11. Lymph | | |
| 6. Hernia | | | 12. Skin | | |

Comments: ____________________________________________________________

**Is the student receiving care for any medical or mental health condition? Yes ( ) No ( )**

Explain: ____________________________________________________________

**Drug Allergies: Yes_____ No_____** If YES, list drug and reaction: ______________________________

**Medications**: ______________________________________________________

**Recommendations for physical activity**: Unlimited ( ) Limited ( )
Define activities to be restricted, if applicable:____________________________________

**Health Care Provider's Signature**:______________________ **Address**: ______________________
**Date**: ______________________ City: ______________________
Printed Name: ______________________ State: ______________ Zip: ______________
License # & State:______________________ Phone: ______________________

**Upload completed form on WSU Health Services website QUESTIONS CALL 413-572-5415**