Return To:
Office of Admissions
Wilberforce University
Wilberforce, Ohio 45384
(937)708-5721

Office use only
Date rec'd _______
Complete________
Incomplete ______
Forwarded ______

YOU WILL NOT BE PERMITTED TO REGISTER FOR CLASS UNTIL THIS HEALTH RECORD IS RECEIVED

This Side To Be Completed By The Student

Name____ SS _____ - _____ - _______

Last First Middle Initial

Date of Birth _____ / _____ / _______

Permanent Address:Street, Apt. ______________________________________

City, State, Zip ______________________________________

Telephone (_____) _____ - _______ Cellular # (_____) _____ - _______ Email ______________________

MEDICAL HISTORY

1. Have you been treated by a physician or nurse practitioner in the past 5 yrs? _____ Yes _____ No

If yes, for what reason? ______________________________________

2. Are you currently taking any medication? _____Yes _____ No

If yes, please list name, dosage, and duration of use:

____

3. Are you allergic to any medication or latex? _____ Yes _____ No

4. Have you ever been hospitalized? _____ Yes _____ No

If yes, for what reason?

____

5. Do you have Medical Insurance? _____ Yes _____ No

If yes, please complete the following:

Company Name: ______________________ Policy / Group Number: ______________________

Subscriber's Name / Relationship: ______________________________________

6. What operations have you had? Give dates: ______________________________________

7. Will you require any special medical attention of facilities? _____ Yes _____ No

List special needs: ______________________________________

____

8. Give month and year of most recent vaccinations: **MMR, Tetanus and PPD are required**

MMR: _____/_____ Tetanus or Td _____/_____ PPD _____/_____ (Was your PPD Positive or negative?) (*Circle one*)

Meningococcal _____/_____ Never taken ______

Hepatitis B First _____/_____ Second _____/_____ Third _____/_____ or Titer _____/_____ Never Taken _____

9. Check all the following that apply to you now or in the past:

___Allergies	___Hepatitis	___Heart Disease	___Sickle Cell
___Anemia	___High Blood Pressure	___Thyroid Disease	___Appendicitis
___Asthma	___Low Blood Pressure	___High Cholesterol	___Stomach, liver, Intestinal Trouble
___Cancer	___Kidney Disease	___Jaundice	___Epilepsy or convulsions
___Diabetes	___Mental Problem	___Tuberculosis	___Skin disease
___Seizures	___Drug /Alcohol Abuse	___Mononucleosis	___Arthritis
___Headaches	___Stomach ulcer/reflux	___Meningitis	

I certify to the best of my knowledge that the above information is complete and correct

Applicant Signature ______________________________ Date ______________

Part II

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

PHYSICAL EXAM

Weight: ________ Height: ________ BP: __________ Pulse: __________ Respirations: __________

Vision: __________ Pap smear Date: ____________ Positive ______ Negative ______

Urinalysis: Protein ________ Glucose ________ Alb ________

List Allergies:

____

CLINCAL EVALUATION

Check each item in the appropriate column	Normal	Abnormal (If Abnormal, describe)	
1. Gen. Appearance	( )	( )	______________
2. Skull, Scalp, Face, Neck, Thyroid	( )	( )	______________
3. Skin, Lymphatics	( )	( )	______________
4. Heart	( )	( )	______________
5. Neck	( )	( )	______________
6. Lungs and Chest	( )	( )	______________
7. Abdomen	( )	( )	______________
8. Extremities	( )	( )	______________
9. Genitalia/Hernia	( )	( )	______________
10. Musculoskeletal	( )	( )	______________
11. Neurological	( )	( )	______________
12. Psychiatric	( )	( )	______________

Please indicate whether this patient has any medical condition which would interfere with regular Physical activities, and/or any special care or treatments needed:

____

____

____

____

____

Signature of Provider Performing Examination ______________________________ Date: ______/______/________

Provider Printed Name: ____

Address: Street, City, State, Zip:

____

Telephone Number: (______) ______ - __________

AUTHORIZATION FOR MEDICAL, DENTAL, SURGICAL OR OTHER TREATMENT

I hereby authorize and consent to any services, including but not limited to diagnostic procedures, radiology procedures, laboratory procedures, anesthesia, medical or surgical treatments, dental procedures or hospital services which are deemed necessary or advisable by the attending physician(s) and rendered to the patient under the general or special instructions of said physician(s). A student under age 18 needs parental consent.

Date: ______/______/__________ Signed: ______________________________________

Parent or Guardian (for minors): ______________________________ Relationship: ______________________

Revised July, 2013

Wilberforce University
Health Care Center

Dear students and parents,

Prior to admission to the University, health records are required to present proof and results of a physical examination along with a copy of immunization records. This should be documented on our student health records and signed by a licensed Physician or Nurse Practitioner. Services are free at the Student Health Care Center. If the student goes to another doctor without a referral from the Student Health Care Center, services will not be paid for. If the student goes to the emergency room and it is not documented as an emergency, it will not be paid for. Therefore, if the patient has insurance through their family which is considered their primary insurance, it should be submitted first. Please send a copy of your insurance card, front and back. Parents should notify their insurance company if their son or daughter will be going to an out of state college.

Authorization for Insurance
Check the following that applies

No, I do not have a primary insurance. ____

Yes, I do have insurance. ____

Insured person (if not patient):

Name: ______________________________ Telephone: (_____) ______ - __________

Address: ______________________________ City /State: ________________ ZIP: ________

Insurance

Primary Insurance Company Name: ____

I.D.# ______________________ Group# __________________ Tel: (_____) _____ -________

I certify that the information that I have reported with regards to my insurance coverage is correct.

Signature ____________________________________ Date _____/_____/________