Dear Students and Parents,

Although Wilberforce University does not provide health insurance, we ask that students provide proof of insurance. Please submit a copy of the student's insurance card along with your required health records. Required health records include the **General Health Form**, **Mandatory Immunization Record Verification Form**, and **Mandatory Physical Exam Form**. All forms must be completed and signed by a licensed Physician or Nurse Practitioner.

Please submit by mail to:

Wilberforce University
Attn: Health Services
Wilberforce University
Wilberforce, OH 45384

All information must be submitted by
December 15 for spring enrollment or July 15 for fall enrollment.

Wilberforce University Health Services
Attn: Health Services
Wilberforce University
Wilberforce, OH 45384
937-708-5738

Name_____
Last First MI

Date of Birth _____/_____/_____ WU ID # _____

Permanent Address Street, Apt. _____

City, State, Zip _____ Primary Telephone _____

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(s)? _____yes _____ no
   If yes, please list the type of reaction that occurs:_____
   Are you allergic to latex? _____yes _____no
   List all known allergies and reactions:_____

4. Have you ever been hospitalized _____yes _____ no
   If yes, for what reason? _____

5. What medical operations have you had? Please provide dates:_____

_____

6. Do you have Medical Insurance? _____yes _____ no

   If yes, please complete the following:

Company Name: _____ Policy/Group Number: _____

   Subscribers Name and Relationship to Subscriber: _____

7. Do you need different assistance through Disability Services or Facilities Management?

List Assistance Requested: _____

_____

Wilberforce University Health Services
Attn: Director of Health Services
Wilberforce University
Wilberforce, OH 45384
937-708-5738

Mandatory Immunization Record Verification Form

Name (Last, First, Middle)

_____

Date of Birth _____ Age_____ WU ID# _____
Current Address _____
City _____ State _____ Zip _____
Student Signature _____ Date _____
(Parent/guardian if student is minor)

Wilberforce University requests that students have the following vaccinations:

- Measles, Mumps & Rubella (MMR) – 2 doses, at least one year apart
- Meningococcal vaccine – one at or after age 16
- Hepatitis B (3 doses)
- Polio (3 doses or positive titer)
- Varicella (chickenpox) (2 doses)
- Tetanus, Diphtheria and Pertussis (Tdap) (within the last 10 yrs.)
- TB test for international students

MMR (Measles, Mumps, Rubella — Combined) Vaccine _____ /_____ /_____ _ _____ /_____ /_____ _

Tetanus or Td _____/ _____ PPD _____/ _____ (Was your PPD Negative or Positive)

Meningococcal A, C, W, Y vaccine received: Yes _____ No _____
If yes, please list the dates: 1 st Dose _____/_____/_____
2 nd Dose _____/_____/_____

Meningococcal B vaccine received: Yes _____ No _____
If yes, please list the dates: 1 st Dose _____/_____/_____
2 nd Dose ____/_____/_____
3 rd Dose _____/_____/_____

Hepatitis B vaccine received: Yes _____ No _____
If yes, please list the dates: 1 st Dose _____/_____/_____
2 nd Dose ____/_____/_____
3 rd Dose _____/_____/_____

Have you had chicken pox (Varicella) or the vaccination?
_____/_____

Have you had a tetanus, Diphtheria and Pertussis vaccination with the last 10 years?
_____/ _____

Health Care Provider: _____ Signature & Stamp _____
(Please print) (Mandatory signature and stamp)

Date: _____ License# _____ Phone # _____

Wilberforce University Health Services
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Wilberforce University
Wilberforce, OH 45384
937-708-5738

Mandatory Physical Exam Form

This form must be completed by your health care provider, dated, signed and stamped.

Weight: _____ Height: _____ BP:_____ Pulse: _____ Respiration: _____
Vision: _____ Pap Smear Date and Result: _____ Urinalysis: Protein _____
Glucose _____ ALB _____ List of Allergies: _____
_____

Clinical Evaluation

Check each item in the appropriate column	Normal	Abnormal (Describe)_____
1. General 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(s) that would interfere with regular physical activities, and or does this patient need any special care or treatment:

_____

_____

_____

Health Care Provider: _____ Signature & Stamp _____
(Please print) (Mandatory signature and stamp)
Date: _____ License# _____ Phone # _____

Wilberforce University Health Services
Attn: Health Services
Wilberforce University
Wilberforce, OH 45384
937-708-5738

Dear Students and Parents,

Wilberforce University provides some basic health services, however, some additional services may have a charge. When additional billing is necessary, we will notify you and may need to bill your primary insurance company. Therefore, we request for you to have an Authorization for Insurance on file with Health Services.

Please make a copy of the front and back of your insurance card, and send the copy with this form.

Insurance Authorization Form

Check the following that apply:

No, I do not have a primary insurance. _____

Yes, I do have primary insurance. _____

Insured person (if not patient):

Name: _____ Telephone: (_____)_____-_____

Address: _____ City/State: _____ Zip:_____

Insurance Information

Primary Insurance Company Name: _____

I.D.# _____ Group#_____ Tel: (_____)_____-_____

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

Signature_____ Date _____/_____/_____