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: ________________________________________________________________
   ___________________________________________________________________________________
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 # ______________________
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

<table>
<thead>
<tr>
<th>Item</th>
<th>Normal</th>
<th>Abnormal (Describe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Appearance</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>2. Skull, Scalp, Face, Neck, Thyroid</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>3. Skin, Lymphatics</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>4. Heart</td>
<td>( )</td>
<td>( ) __________________________</td>
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<tr>
<td>5. Neck</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>6. Lungs and Chest</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>7. Abdomen</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>8. Extremities</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>9. Genitalia/Hernia</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>10. Musculoskeletal</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>11. Neurological</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
<tr>
<td>12. Psychiatric</td>
<td>( )</td>
<td>( ) __________________________</td>
</tr>
</tbody>
</table>

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 # ____________________________
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 _____/_____/_______