

**Wheeling Jesuit University ♦ Doctorate of Physical Therapy Program
Pre-Entrance Health Record Requirements**

All Health Forms Must Be Completed and Returned To WJU By July 15

PLEASE PRINT CLEARLY

Name: (Last) _____ (First) _____ (Middle) _____ Sex: M ___ F ___
Date of Birth: (mo) _____ (day) _____ (yr) _____ Email you check regularly: _____
(Street Address) _____ (City) _____
(State or Country) _____ (Zip) _____ Home Telephone: [_____] _____
Please check: commuter ___ campus resident ___ Student Cell: [_____] _____
Year Entering _____ Semester Entering _____
Emergency Contact Person: _____ Relationship: _____
(Street) _____ (City) _____ (State/Country) _____ (Zip) _____
Home Telephone: [_____] _____ Alternative Telephone Number: [_____] _____
Emergency contact email: _____
Name of Family Physician/Health Care Provider: _____ Telephone: [_____] _____
(Street) _____ (City) _____ (State/Country) _____ (Zip) _____

MEDICAL INSURANCE COVERAGE

This requirement is to ensure that all students will have access to medical care, if needed. Your medical insurance information will be kept confidential and on file for scheduling medical referrals to outside physicians, outpatient treatment, emergencies, and participation in the Doctorate of Physical Therapy Program at Wheeling Jesuit University.

I, (print name) _____, hereby confirm that I am currently covered by health insurance and will maintain health insurance coverage throughout my tenure, both didactic and clinical, while in the Doctorate of Physical Therapy Program at Wheeling Jesuit University.

A readable copy of the front and back of my insurance card is attached.

Name: (please print) _____ Signature: _____ Date: _____

AUTHORIZATION TO RENDER HEALTH SERVICES

I hereby authorize the Wheeling Jesuit University's Health Center to render services deemed necessary for my health and well-being. I grant permission for my transfer to an accredited hospital or other care facility if deemed necessary by the Dean of Student Development or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my treatment by their facility to the Wheeling Jesuit University Health Center for continuity of care.

Name: (please print) _____ Signature: _____ Date: _____

PHYSICAL

It is mandatory that all students in the Doctorate of Physical Therapy Program at Wheeling Jesuit University submit a completed enrollment physical (dated between April 1 to June 1, 2011) **and** submit documentation of an annual physical thereafter.

I hereby state that a licensed physician or nurse practitioner completed my physical (attached form). I also agree to maintain my physical, annually, and to provide a copy to WJU's Health Center.

Name: (please print) _____ Signature: _____ Date: _____

Wheeling Jesuit University ♦ Doctorate of Physical Therapy Program

PERSONAL HEALTH HISTORY TO BE FILLED OUT BY STUDENT **MANDATORY REQUIREMENT FOR ALL RESIDENTS AND COMMUTERS**

This information will be used only as an aid in the consideration of your health needs and will remain confidential among the appropriate healthcare professionals. PLEASE USE ADDITIONAL SHEETS OF PAPER IF NECESSARY.

- Are you presently under any medical treatment? Yes No
If yes, explain: _____
- Are you taking any medications at present (prescription, nonprescription, inhaler)? Yes No
If yes, explain: _____
- Are you now receiving or have you ever received professional help for emotional or psychological problems? Yes No
If yes, when: _____
- Do you have a physical impairment such as paralysis, loss of vision, hearing, etc.? Yes No
If yes, explain: _____
- Do you have any sensitivity to food, medicine, or environmental contact? Yes No
If yes, explain: _____
- Have you ever had a head injury or concussion? Yes No
If yes, explain and give dates: _____
- Has a physician ever denied or restricted your participation in sports for any health problems? Yes No
If yes, explain: _____

Have you ever had, or do you currently have:

- | | | | |
|---------------------------------------------------------------------------------------------------|---------------------------------------------|-----------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Nervous Tendencies | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heat Related Illness |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Asthma, Hay Fever, or Hives |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Convulsions or "black outs" | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pregnancies - Date of last menstrual period: _____ | |
| <input type="checkbox"/> Loss of function of a "paired organ" (eye, ear, testicle, ovary, kidney) | | | |
| <input type="checkbox"/> NONE OF THE ABOVE | | | |

If you checked any of the above, please provide further information: _____

Dates of significant injuries or operations or medical admissions to hospitals: NONE _____

Personal Habits (please indicate use of any of the following):

- Smoking tobacco Smokeless Tobacco Alcohol Dietary Supplements Dental appliances NONE

If you wish to receive care for any health problem or concern at the WJU Student Wellness Center, please bring copies of any appropriate medical records with you to campus and call (304) 243-2275 for an appointment with a physical or mental health professional.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. I also state that a physician, licensed nurse or authorized person completed the Immunization form.

Print Name: _____

Student Signature: _____ Date: _____

The Registered Nurse or Counselor may request a consult with the you for basic information and support purposes. Reviewed by: WJU RN: _____ Date: _____ Reviewed by WJU Counselor (LPC): _____ Date: _____

PLEASE MAKE A COPY OF YOUR PRE-ENTRANCE HEALTH RECORD FOR YOUR FILES BEFORE SUBMITTING TO

WHEELING JESUIT UNIVERSITY
Health Center
316 Washington Ave.
Wheeling, WV 26003

DEADLINE: ALL FORMS MUST BE RECEIVED BY JULY 15.

We must receive ALL forms before you arrive on campus, allowing time to review, process, and, if necessary, alert you of missing immunizations, giving you time to complete and/or bring your records up-to-date.

For questions or concerns, please call the Health Center (304)243-2275 or 1-800-624-6992, ext. 2275.

Wheeling Jesuit University ♦ Doctorate of Physical Therapy Program

MANDATORY REQUIREMENT FOR RESIDENTS AND COMMUTERS

All Completed Forms Must Be Returned to WJU By July 15

YOUR PHYSICIAN OR NURSE PRACTITIONER MUST COMPLETE, SIGN, AND DATE THIS FORM.

PLEASE PRINT

STUDENT NAME: Last First Middle Initial Date of Birth:

Family history:

Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

- Cancer Diabetes Asthma, Hay Fever, or other Allergies
Heart Disease Marfan's Disease Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies:

Height: Weight: Blood Pressure: Pulse:

LIST MEDICATIONS:

Table with 3 columns: Normal, Abnormal, Notes of Abnormality. Rows include Skin, Hearing, Head, Ear, Nose, & Throat, Neck: Thyroid, Cardiovascular, Lungs, Breasts, Abdomen, Genitalia, Menstruation, Back & Extremities, Reflexes.

ALLERGIES/REACTIONS:

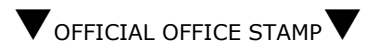
Latex: food:
dyes: medication:

(REQUIRED RESPONSE) Does this student have any past or current physical or emotional conditions that you consider important?

(REQUIRED RESPONSE) Is this student presently under medical therapy or psychological counseling?

Recommendations:

Name of Physician OR NP (print):



Phone: Fax:

Address: (Street) (City) (State) (Zip)

Signature of Physician OR NP: Date:

Wheeling Jesuit University ♦ Doctorate of Physical Therapy Program
Student Pre-Entrance Immunizations & Tuberculosis Screening Requirement
For Residents & Commuters

All Health Forms Must Be Completed and Returned To WJU By July 15

An accurate record of immunizations is required as part of the admissions procedure for all WJU students born after 1956. This may be obtained from your private physician/healthcare provider or health department. Your Board of Education is one source for official proof of primary records.

- This form must be completed, signed and dated by a healthcare provider.
- Medical or religious exemptions to the requirements must be verified with a letter on official stationery and signed by a physician or church official.
- Wheeling Jesuit University requires all new students, commuters and residents, to submit proof of immunizations required by the University.
- This completed form must be submitted before attending classes or residing in the residence halls.

STUDENT NAME (please print): (Last) _____ (First) _____ (Middle Initial) _____

HEALTH CARE PROVIDER: IN ADDITION TO COMPLETING THIS FORM, PLEASE ATTACH A COPY OF IMMUNIZATION RECORDS.

- A. (MMR) Measles, Mumps, Rubella #1 _____ #2 _____
AND a titer (lab work). Please attach a copy with Physician's signature on the result page.
- B. (IPV or OPV) Polio Series #1 _____ #2 _____
 #3 _____ Booster _____
- C. (Tdap) Tetanus-Diphtheria-Pertussis vaccination or booster within the last 10 years is required. A substitute one-time dose of Tdap for Td booster, then boost with a Td every 10 years for persons aged 19-54. #1 _____
- D. (Hepatitis B) vaccine series #1 _____ #2 _____ #3 _____
- E. (Meningococcal) Bacterial Meningitis Vaccination **OR** completed WJU Meningococcal waiver.
(Vaccine is strongly recommended but not required if attached waiver is signed.) #1 _____
- F. Varicella (chickenpox) Had disease? _____
OR date(s) of immunization if did not have disease. #1 _____ #2 _____
AND a titer (lab work). Please attach a copy with Physician's signature on the result page.
- H. (PPD) Tuberculosis Mantoux Test. [A Tine or Monovac are not accepted]. Documentation of a 2-Step PPD placed within six months prior to the start of WJU classes. **NOTE: All international students are required to have the PPD screening regardless of a previous BCG vaccination.** If it is impossible for the student to receive the PPD screening in their home country, the student must complete the PPD screening within 7 days of their arrival on campus.

1st of 2-STEP PPD PLACEMENT DATE: _____ READ DATE: _____ RESULT: _____ mm pos. OR _____ mm neg.

2nd of 2-STEP PPD PLACEMENT DATE: _____ READ DATE: _____ RESULT: _____ mm pos. OR _____ mm neg.

If positive, DATE OF CHEST-XRAY: _____ RESULT: negative _____ or positive _____

IF CHEST X-RAY IS POSITIVE, DEFINE TREATMENT: _____

Physician or Healthcare Provider (print) [_____] **Telephone** **▼ OFFICIAL OFFICE STAMP ▼**

Signature of Physician Or Authorized Person _____ **Address** _____ **Date** _____

MENINGOCOCCAL VACCINE WAIVER FORM

A few years ago, research by the Center for Disease Control (CDC) found that students appear to be at higher risk for meningococcal disease than college students overall. The College and University Student Vaccination Act has been in effect in many states since. It states that all students residing in campus housing receive a one-time vaccination against meningococcal disease **or** sign a waiver for religious or other reasons after they have been provided with information on the risks associated with the disease and the effectiveness of the vaccine. Given the seriousness of meningococcal disease, Wheeling Jesuit University strongly recommends that all students receive a vaccination against this meningitis, regardless of their residential status. Any student choosing not to receive this vaccination must sign this waiver indicating that they understand the risks associated with meningococcal disease and the availability and effectiveness of the vaccine. If a student is a minor, the students' parents also must sign this waiver.

What is meningitis?

Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. People sometimes refer to it as spinal meningitis. Meningitis is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. For bacterial meningitis, it is also important to know which type of bacteria is causing the meningitis because antibiotics can prevent some types from spreading and infecting other people. Before the 1990s, *Haemophilus influenzae* type b (Hib) was the leading cause of bacterial meningitis, but new vaccines being given to all children as part of their routine immunizations have reduced the occurrence of invasive disease due to *H. influenzae*. Today, *Streptococcus pneumoniae* and *Neisseria meningitidis* are the leading causes of bacterial meningitis. This information has been taken from the Center for Disease Control website. We encourage students to visit < <http://www.cdc.gov/>> to receive more information about meningitis before signing this waiver.

STUDENT RELEASE UPON REFUSAL OF IMMUNIZATION AGAINST MENINGITIS

I understand that it is recommended that all university students receive the vaccination against meningococcal disease. I understand that by declining this vaccine, I continue to be at risk of acquiring meningitis, a serious disease. I, also, understand that the majority of clinical placement sites are requiring evidence of meningococcal disease immunity before accepting health science students for clinical practice and I acknowledge that, if I do not have evidence of this immunity, my placement for clinical practice may be affected (if applicable).

Despite the risks described above, I request that my refusal be honored, and I hereby release Wheeling Jesuit University, its officers, trustees, employees and agents as well as any clinical agency in which I practice due to any student role from any and all liability that may arise directly or indirectly as a result of my refusal of the meningococcal disease vaccine.

I _____ refuse immunization against meningitis.
(Print name)

Signature: _____ Date: _____

Please return with your completed health form to the Health Center.