

WHEELING JESUIT UNIVERSITY

Personal Health History

(Mandatory for residents AND commuters.)

FOR OFFICE USE ONLY

Reviewed by: WJU RN: _____ Date: _____

WJU Counselor (LPC): _____ Date: _____

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 presently taking any medications (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, loss of 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 (CHECK ALL THAT APPLY):

- | | | | |
|--|--|--|---|
| <input type="radio"/> Chicken Pox | <input type="radio"/> Nervous Tendencies | <input type="radio"/> Rheumatic Fever | <input type="radio"/> Heat Related Illness |
| <input type="radio"/> Heart Disease | <input type="radio"/> Mononucleosis | <input type="radio"/> Tuberculosis | <input type="radio"/> Asthma, Hay Fever, or Hives |
| <input type="radio"/> Hepatitis | <input type="radio"/> Diabetes | <input type="radio"/> Convulsions or "Black Outs" | <input type="radio"/> Eating Disorders |
| <input type="radio"/> Seizures | <input type="radio"/> Heart Murmur | <input type="radio"/> Pregnancies (Date of last menstrual period: ___/___/___) | |
| <input type="radio"/> Loss of function of a "paired organ" (eye, ear, testicle, ovary, kidney) | | | |
| <input type="radio"/> 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 Health Center, please bring copies of any appropriate medical records with you to campus and call (304) 243-2275 for an appointment.

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 licensed Physician or Nurse Practitioner completed my physical and that a licensed nurse or authorized person completed the immunization form.

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

Parent/guardian (if student is under the age of 18): (print) _____ Signature: _____ Date: _____

(The Registered Nurse or Counselor may request a consult with the student for basic information and support purposes.)

PLEASE MAKE A COPY OF YOUR PRE-ENTRANCE HEALTH RECORD FOR YOUR FILES BEFORE SUBMITTING TO
ADMISSIONS OFFICE
WHEELING JESUIT UNIVERSITY
316 Washington Ave., Wheeling, WV 26003

DEADLINES TO SUBMIT HEALTH RECORDS: July 15 for Fall Enrollment December 1 for Spring Enrollment May 1 for Summer Enrollment
It is important that we 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

Physical Form

(Mandatory for residents AND commuters.)

Please return completed forms by:
July 15 for **Fall Enrollment**
December 1 for **Spring Enrollment**
May 1 for **Summer Enrollment**

IF YOU WILL BE A WJU ATHLETE, please use the physical form provided to you by the Athletic Department, instead of this form. Please provide a copy of your athletic physical to the Admissions Office along with your other pre-entrance health forms. To avoid enrollment records from being misplaced, please be sure to send your pre-entrance health forms to the Admissions office, not to the Athletic Department.

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

PLEASE PRINT

Student Name: _____ Date of Birth: ____/____/____
LAST FIRST MID. INT. MM DD YYYY

FAMILY HISTORY

Among student's 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 Sudden death under age 50 from non-trauma cause

Please explain any of the above marked replies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

List Student's Medications: _____

			Notes of Abnormality
Skin	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Hearing	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Head	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Ear, Nose, & Throat	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Neck: Thyroid	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Cardiovascular	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Lungs	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Breasts	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Abdomen	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Genitalia	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Menstruation	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Back & Extremities	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____
Reflexes	<input type="radio"/> Normal	<input type="radio"/> Abnormal	_____

Allergies/Reactions:

Latex Food (list): _____

Dyes (list): _____ Medication (list) _____

Other: _____

Does this student have any past or current physical or emotional conditions that you consider important? _____

Is this student presently under medical therapy or psychological counseling? _____

Recommendations: _____

Name of Physician / NP (print): _____

Phone: (____) _____ Fax: (____) _____

Address: _____ State/Country: _____ Zip: _____

Signature of Physician / NP: _____ Date: _____

OFFICIAL OFFICE STAMP

WHEELING JESUIT UNIVERSITY

Pre-Entrance Immunization & Tuberculosis Screening

(Mandatory for residents AND commuters.) Please return completed forms by: **July 15** for **Fall Enrollment** **Dec. 1** for **Spring Enrollment** **May 1** for **Summer Enrollment**

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: _____
LAST FIRST MID. INT.

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

A. (MMR) Measles, Mumps, Rubella #1 _____ #2 _____

B. (IPV or OPV) Polio Series #1 _____ #2 _____ #3 _____ Booster _____

C. (Tdap) Tetanus-Diphtheria-Pertussis vaccination or booster #1 _____
within the last 10 years is required. A substitute one-time dose of Tdap for Td booster; then boost with Td every 10 years for persons aged 19-64.

D. (Hepatitis B) vaccine series OR a positive titer (lab work) OR #1 _____ #2 _____ #3 _____
completed WJU waiver. NOTE: If you are in the process of completing the series, please fill out the waiver form.
(VACCINE IS STRONGLY RECOMMENDED BUT NOT REQUIRED IF THE WAIVER IS SIGNED - PAGE 5)

E. (Meningococcal) Bacterial Meningitis Vaccination OR #1 _____
completed WJU Meningococcal waiver.
(VACCINE IS STRONGLY RECOMMENDED BUT NOT REQUIRED IF A WAIVER IS SIGNED - PAGE 6)

F. Chickenpox — had disease? Yes (approximate age) _____ No

G. (Varicella) Chickenpox Vaccination (highly recommended #1 _____ #2 _____
but not mandatory if you have not had chickenpox.

H. (PPD) Tuberculosis Mantoux Test. [A Tine or Monovac are not accepted]. Documentation of a PPD placed within twelve months prior to the start of WJU classes will be accepted. **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.

DATE OF PPD PLACEMENT: _____ READ DATE: _____ RESULT: Positive _____ mm Negative _____ mm

DATE OF CHEST-XRAY, if positive: _____ RESULT: Negative Positive

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

Name of Physician / NP (print): _____

Phone: (____) _____ Fax: (____) _____

Address: _____ State/Country: _____ Zip: _____

Signature of Physician / NP: _____ Date: _____

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