

WHEELING JESUIT UNIVERSITY

Tips to Help You Complete Your Undergraduate Pre-enrollment Health Packet

1. Please note the deadline of submission: **JULY 1** for Fall enrollment and **DECEMBER 1** for Spring enrollment.
2. Please print clearly.
3. Please make sure that pages 1 & 2 have been completely filled out and that signatures and dates are provided.
4. If you will live in campus housing or if you are a non-citizen International (including ELI) student, please indicate if you have medical insurance. If you do, be sure to provide a copy of the front and back of your insurance card **OR** a letter of verification from your insurance provider. If you do not, the University will enroll you in a University plan and you will be billed accordingly.
5. Physical form (page 5): your physical must be completed by a physician or a nurse practitioner. The authorized health care provider must complete his/her contact information at the bottom of the physical form.

A physical dated within twelve months to the start of your first semester start date will be accepted.

If you will be a WJU athlete — please use your athletic form provided by the athletic department. Send a *copy* of your athletic physical with your health packet to the Admissions office. To avoid enrollment health records from being misplaced, please **do not** send them to the Athletic Department. **Do** send your original athletic physical to the Athletic Department.

6. Immunizations and tuberculosis screening (page 4): **Start gathering immunizations early.**

This form is to be completed, signed and dated, by your health care provider. Original documentations from other health care providers must be attached.

- **MMRs** (measles/mumps/rubella) and **polio** vaccines: if you cannot find official documentation of MMR (2 doses) and polio (3 doses) vaccines, please contact your high school or board of education for a copy. A titer (lab work) showing immunity will be accepted if you cannot obtain verification of the vaccines.
- An initial **Tdap** (tetanus/diphtheria/**AND pertussis**) vaccine must be dated after 2005. After initial Tdap, Td booster every 10 years will be accepted.
- **Hepatitis B** vaccine: documentation of vaccines (3 dose series) **OR** a titer (lab work) showing immunity will be accepted. Although the vaccine is strongly recommended, you may opt to waive this vaccine by completing the WJU waiver form. **Please note: some health science majors may be required to have this vaccine and/or titer (lab work) for clinical education rotations.**
- **Meningococcal** vaccine: This vaccine is strongly recommended, but not required if the WJU waiver is completed.
- **Varicella** (chicken pox) vaccine: This vaccine is highly recommended, but not mandatory. Please indicate on page 2 of the health form if you have had the disease and the approximate year or age. **Please note: some health science majors may be required to have this vaccine and/or titer (lab work) for clinical education rotations.**
- **PPD** (tuberculosis screening): a one-step PPD is required for enrollment to WJU. The screening date should be within one year of the start of your first day of class at WJU. **Please note: health science majors should have an initial two-step PPD and follow-up with an annual one-step.**

Pre-Entrance Health Record Requirements for WJU Students

Please return all completed forms by:

July 1 for Fall Enrollment

December 1 for Spring Enrollment

May 1 for Summer Enrollment

PLEASE PRINT CLEARLY

Name: _____ Sex: M F
LAST FIRST MIDDLE

Date of Birth: / / Email you check regularly: _____
MM DD YYYY

Address: _____ City: _____ State/Country: _____ Zip: _____

Home Phone: (____) _____ Student Cell Phone: (____) _____ Please check one: Commuter Campus Resident

Year Entering: _____ (Please check): Entering Fall Semester Entering Spring Semester Entering Summer Student

Please check: Entering as a Freshman Re-admitted to WJU Transferring in Graduate student ELI student

Will you be a WJU athlete? Yes No If yes, what sport(s)? _____

My intended major (s): _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ State/Country: _____ Zip: _____

Home Phone: (____) _____ Alternative Phone: (____) _____

Emergency Contact Email: _____

Family Physician / Health Care Provider: _____ Phone: (____) _____

Address: _____ State/Country: _____ Zip: _____

MANDATORY MEDICAL INSURANCE COVERAGE - Required for students living on campus, non-citizen ELI and International Students only.

This requirement is to ensure that students living on campus housing and those who are not U.S. citizens 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/or participation in the University athletic program. Residential and non-U.S.-citizen students who do not provide proof of medical insurance by July 1 will be automatically enrolled in and billed for a medical insurance program through the University. Please sign and date.

I, (print name) _____, hereby confirm that I am currently covered by health insurance and will maintain health insurance coverage throughout my academic studies at Wheeling Jesuit University. **A clean, readable copy of the front and back of my insurance card is attached.**

Signature: _____ Date: _____

AUTHORIZATION TO RENDER HEALTH SERVICES (IF YOU ARE 18 YEARS OF AGE OR OLDER).

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.

Student Signature: _____ Date: _____

AUTHORIZATION FROM PARENT/GUARDIAN IF YOU ARE A MINOR (UNDER THE AGE OF 18).

I hereby authorize the Wheeling Jesuit University's Health Center to render confidential health services deemed necessary for my/our minor child's health and well-being. These services are inclusive of nursing services and counseling support services.

In addition, I grant permission for my child's 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 child's insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my child's treatment by their facility to the Wheeling Jesuit University Health Center for continuity of care.

Parent/Guardian Signature: _____ Date: _____

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 1 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.

Physical Form

(Mandatory for residents AND commuters.)

Please return completed forms by:
July 1 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.

A 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: _____

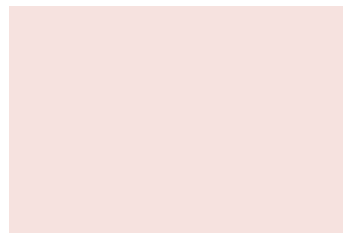
Name of Physician / NP (print): _____

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

Address: _____ State/Country: _____ Zip: _____

Signature of Physician / NP: _____ Date: _____

OFFICIAL OFFICE STAMP



Pre-Entrance Immunization & Tuberculosis Screening

(Mandatory for residents AND commuters.) Please return completed forms by: **July 1** 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 — either a physician or nurse practitioner.
- + 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: _____

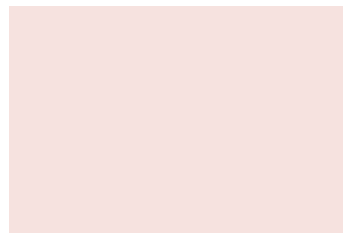
Name of Physician / NP (print): _____

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

Address: _____ State/Country: _____ Zip: _____

Signature of Physician / NP: _____ Date: _____

OFFICIAL OFFICE STAMP



Hepatitis B Vaccine Waiver Form

Hepatitis B is a serious disease caused by the hepatitis B virus (HBV) that attacks the liver and can be spread to others. The Center for Disease Control (CDC) recommends that workers who perform tasks that involve exposure to blood or blood-contaminated body fluids should be vaccinated. Consequently, the majority of health care agencies require all workers who may be at risk to be vaccinated. In addition, health care agencies used as clinical practice sites require Hepatitis B immunity for all health science students. If you have not received the recombinant hepatitis B vaccine and are a health science student, your placement for clinical practice could be affected.

What is hepatitis B?

Hepatitis B is a contagious liver disease that results from infection with the hepatitis B virus and means inflammation of the liver. It can range in severity from a mild illness lasting a few weeks to a serious, lifelong illness. Hepatitis B is usually spread when blood, semen, or another body fluid from a person infected with the hepatitis B virus enters the body of someone who is not infected. This can happen through sexual contact with an infected person or sharing needles, syringes, or other drug-injection equipment. Hepatitis B can also be passed from an infected mother to her baby at birth.

Hepatitis B can be either acute or chronic. Acute hepatitis B virus infection is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus. Acute infection can — but does not always — lead to chronic infection. Chronic hepatitis B virus infection is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Chronic hepatitis B is a serious disease that can result in long-term health problems, and even death.

The best way to prevent hepatitis B is by getting vaccinated. This information has been taken from the Center for Disease Control website. We encourage students to visit www.cdc.gov to receive more information about hepatitis B before signing this waiver.

STUDENT RELEASE UPON REFUSAL OF IMMUNIZATION AGAINST HEPATITIS B

I understand that it is recommended that all university students who do not have evidence of immunity to Hepatitis B virus receive the Hepatitis B vaccine. The recombinant B vaccine is a genetically engineered vaccine derived from the hepatitis B surface antigen produced in yeast cells (common baker's yeast). I understand that if I have an allergy or sensitivity to yeast, I should not receive the vaccine. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. I, also, understand that the majority of clinical placement sites are requiring evidence of Hepatitis B virus immunity before accepting health science students for clinical practice and I acknowledge that, if I do not have evidence of HBV 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 Hepatitis B vaccine.

I, (PLEASE PRINT NAME) _____, refuse or am in the process of completing the series of Hepatitis B vaccinations. I understand the risks as stated above apply until the series is completed.

Signature of student: (Signature of parent/guardian is required if student is under age 18.) _____ Date: _____

Students choosing a health professions major must complete the Hepatitis B series.

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 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, (PLEASE PRINT NAME) _____, refuse immunization against meningitis. I understand the risks as stated above apply.

Signature of student: (Signature of parent/guardian is required if student is under age 18.) _____ Date: _____

Please return with your completed health form to the Admissions Office