

**Wheeling Jesuit University**  
**Pre-Entrance Health Record Requirements For WJU Students**

**All Forms Must Be Completed and Returned By: July 15 For Fall Enrollment OR  
December 1 For Spring Enrollment OR May 1 for Summer Enrollment.**

**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 \_\_\_\_\_ Please check: Entering Fall Semester \_\_\_ Entering Spring Semester \_\_\_ Entering Summer Student \_\_\_  
Please check: Entering as a Freshman \_\_\_ Re Admitted \_\_\_ Transfer Student \_\_\_ Graduate student \_\_\_  
Will you be a WJU athlete? Yes \_\_\_ No \_\_\_ If so, what sport? \_\_\_\_\_

=====

**PLEASE PRINT CLEARLY**

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) \_\_\_\_\_

**ALL FULL-TIME WJU STUDENTS MUST PROVIDE PROOF OF HAVING 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/or participation in University athletics.

Insurance company/provider: \_\_\_\_\_ Policy No. \_\_\_\_\_ Group No. (if applicable) \_\_\_\_\_

**YOU MUST ALSO PROVIDE A FRONT/BACK COPY OF YOUR INSURANCE CARD WITH THIS FORM.**

**STUDENT SIGNATURE REQUIRED IF AGE 18 OR OVER.**

I hereby authorize the WJU 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.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT/GUARDIAN SIGNATURE REQUIRED IF STUDENT IS UNDER THE AGE OF 18.**

I hereby authorize the WJU Health Center to render services deemed necessary for my student's health and well-being. I grant permission for my student'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 student's insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my student's treatment by their facility to the Wheeling Jesuit University Health Center for continuity of care.

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**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):
- |  |  |                                  |  |  |                               |
|--|--|----------------------------------|--|--|-------------------------------|
| <input type="checkbox"/> Smoking tobacco | <input type="checkbox"/> Smokeless Tobacco | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Dietary Supplements | <input type="checkbox"/> Dental appliances | <input type="checkbox"/> 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 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 licensed Physician or Nurse Practitioner completed my Physical and that a licensed nurse or authorized person completed the Immunization form.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If under the age of 18)

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

OFFICE OF ENROLLMENT  
 WHEELING JESUIT UNIVERSITY  
 316 Washington Ave.  
 Wheeling, WV 26003

**DEADLINES TO SUBMIT HEALTH RECORDS: July 15 For Fall Enrollment OR  
 December 1 For Spring Enrollment OR May 1 for Summer Enrollment.**

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.

# WJU MANDATORY REQUIREMENT FOR RESIDENTS AND COMMUTERS

**All Forms Must Be Completed and Returned By: July 15 For Fall Enrollment OR  
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**YOUR PHYSICIAN OR NURSE PRACTITIONER MUST COMPLETE, SIGN, AND DATE THIS FORM.**

**PLEASE PRINT**

**STUDENT NAME:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Initial

**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:** \_\_\_\_\_

Normal	Abnormal	Notes of Abnormality
_____ Skin	_____	
_____ Hearing	_____	
_____ Head	_____	
_____ Ear, Nose, & Throat	_____	
_____ Neck: Thyroid	_____	
_____ Cardiovascular	_____	
_____ Lungs	_____	
_____ Breasts	_____	
_____ Abdomen	_____	
_____ Genitalia	_____	
_____ Menstruation	_____	
_____ Back & Extremities	_____	
_____ Reflexes	_____	

**ALLERGIES/REACTIONS:**

Latex: \_\_\_\_\_ food: \_\_\_\_\_

dyes: \_\_\_\_\_ medication: \_\_\_\_\_

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? \_\_\_\_\_

**ATHLETIC CLEARANCE**

Cleared  Cleared after completing evaluation/rehabilitation for: \_\_\_\_\_

Not cleared for Sports: \_\_\_\_\_ Reason: \_\_\_\_\_

Recommendations: \_\_\_\_\_

Name of Physician OR NP (print): \_\_\_\_\_



Phone: [\_\_\_\_\_] \_\_\_\_\_ Fax: [\_\_\_\_\_] \_\_\_\_\_

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

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

# Wheeling Jesuit University

## Student Pre-Entrance Immunization & Tuberculosis Screening Requirement For Residents & Commuters

**All Forms Must Be Completed and Returned By: July 15 For Fall Enrollment OR  
December 1 For Spring Enrollment OR 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.
- Students need to complete and submit this form before attending classes or residing in the residence halls.

**STUDENT NAME (please print):** (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

**PLEASE HAVE YOUR CURRENT DOCTOR OR HEALTH CARE PROVIDER USE THIS FORM TO ADD OR UPDATE ANY  
NEEDED IMMUNIZATIONS TO MEET YOUR PRE-ENTRANCE REQUIREMENTS.  
OFFICIAL INDIVIDUAL COPIES FROM OTHER HEALTH CARE PROVIDERS MUST ACCOMPANY THIS FORM.**

### DATES

\_\_\_\_\_ (MMR #1) Measles, Mumps, Rubella. Immunized at 12 months or after & before 5 years.

If given individually: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_

\_\_\_\_\_ (MMR #2) Measles, Mumps, Rubella. Immunized at 5 years of age or later.

If given individually: Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_

\_\_\_\_\_ (Tdap) Tetanus-Diphtheria-Pertussis vaccination or booster within the last 10 years. A booster within the last 6 years is recommended. A Tetanus vaccine without diphtheria or pertussis is not accepted.

\_\_\_\_\_ (one-step PPD **PLACEMENT**) 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. Arrangements for a local PPD screening can be made through the Health Center.

\_\_\_\_\_ (PPD **READ RESULT**) Date of Tuberculosis Mantoux Test reading.

1. Result: Positive \_\_\_\_\_ mm/induration Negative \_\_\_\_\_

2. If PPD is positive a Chest x-ray is required. DATE OF X-RAY: \_\_\_\_\_

3. Result of X-ray: Negative \_\_\_ Positive \_\_\_ Please define treatment: \_\_\_\_\_

(IPV or OPV) Polio Series #1 \_\_\_\_\_, #2 \_\_\_\_\_, #3 \_\_\_\_\_, Booster \_\_\_\_\_

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_ (Hepatitis B) vaccine series OR a positive titer (lab work) OR 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)**

\_\_\_\_\_ (Meningococcal) Bacterial Meningitis Vaccination OR completed WJU Meningococcal waiver

**(VACCINE IS STRONGLY RECOMMENDED BUT NOT REQUIRED IF A WAIVER IS SIGNED – PAGE 6)**

\_\_\_\_\_ Approximate year or age of having Chickenpox. Please indicate if did not have chickenpox: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_ Varivax Vaccination (highly recommended, but not mandatory) if you have not had chickenpox.

\_\_\_\_\_  
**Physician or Healthcare Provider (print)** [\_\_\_\_\_] \_\_\_\_\_  
**Telephone**

▼ **OFFICIAL OFFICE STAMP** ▼

\_\_\_\_\_  
**Signature of Physician Or Authorized Person** \_\_\_\_\_ **Address** \_\_\_\_\_ **Date** \_\_\_\_\_

## HEPATITIS B 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 < <http://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)

**Please return with your completed health form to the Office of Enrollment.**

## 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 of student. Signature of parent/guardian is required if student is under age 18.)

\_\_\_\_\_  
(Date)

**Please return with your completed health form to the Office of Enrollment.**