

**Wheeling Jesuit University**  
**2008-2009 Pre-Entrance Health Record Requirements**  
**This Form Must Be Returned By July 15, 2008.**

**PLEASE PRINT**

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ Sex: M \_\_\_ F \_\_\_  
Date of Birth: (mo) \_\_\_\_\_ (day) \_\_\_\_\_ (yr) \_\_\_\_\_ Email you check regularly: \_\_\_\_\_  
(Street Address) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_ (Zip) \_\_\_\_\_  
Home Telephone: [\_\_\_\_\_] \_\_\_\_\_ Student Cell: [\_\_\_\_\_] \_\_\_\_\_  
Please check: commuter \_\_\_ campus resident \_\_\_  
Please check: Entering Fall Semester \_\_\_ Entering Spring Semester \_\_\_  
Please check one: Entering as a Freshman \_\_\_ Transfer student \_\_\_\_\_

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**PLEASE PRINT**

Emergency Contact Person: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_ (Zip) \_\_\_\_\_  
Home Telephone: [\_\_\_\_\_] \_\_\_\_\_ Alternative Telephone Number: [\_\_\_\_\_] \_\_\_\_\_  
Parent email contact: \_\_\_\_\_  
Name of Family Physician/Health Care Provider: \_\_\_\_\_ Telephone: [\_\_\_\_\_] \_\_\_\_\_  
(Street) \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_ (Zip) \_\_\_\_\_

**ALL STUDENTS MUST HAVE MEDICAL INSURANCE COVERAGE. YOU MUST PROVIDE A FRONT/BACK COPY OF YOUR INSURANCE CARD.**  
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) \_\_\_\_\_

IF YOU DO NOT HAVE PRIVATE COVERAGE, PLEASE FIND ENCLOSED A BROCHURE FROM AN INSURANCE PROVIDER. ALL STUDENTS MUST HAVE MEDICAL INSURANCE COVERAGE.

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

I hereby authorize the WJU Student Wellness and Counseling Center to employ diagnostic procedures and to render any treatment, or medical, surgical, psychological, or psychiatric care 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 medical or mental health provider. 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 Student Wellness & Counseling Center for continuity of care.

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

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

I hereby authorize the WJU Student Wellness and Counseling Center to employ diagnostic procedures and to render any treatment, or medical, surgical, psychological, or psychiatric care deemed necessary for the health and well-being of my child. I grant permission for the transfer of my child to an accredited hospital or other care facility if deemed necessary by the medical or mental health provider. 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 child's treatment by their facility to the Wheeling Jesuit University Student Wellness & Counseling Center for continuity of care.

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

## PERSONAL HISTORY TO BE FILLED OUT BY STUDENT

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) |   |   |  |

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

Dates of significant injuries or operations or medical admissions to hospitals: \_\_\_\_\_

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

- Smoking tobacco       Smokeless Tobacco       Alcohol       Dietary Supplements       Dental appliances

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 the Wellness & Mental Health Counseling professionals.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

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**

WHEELING JESUIT UNIVERSITY

Office of Admissions  
316 Washington Ave.  
Wheeling, WV 26003

**DEADLINES TO SUBMIT HEALTH RECORDS: FALL ENROLLMENT: JULY 15, 2008  
SPRING ENROLLMENT: DECEMBER 1, 2008**

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 Office of Admissions at (304)243-2359 or 1-800-624-6992, ext. 2359.

**This Form Must Be Completed and Returned by July 15, 2008.**

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

**PLEASE PRINT**

**STUDENT NAME:** \_\_\_\_\_  
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: \_\_\_\_\_

**EYE EXAMINATION:** Pupils:  Equal                       Unequal                      Distant Vision: Right 20/\_\_\_\_ Cor. To 20/-\_\_\_\_  
 Glasses                       Contact Lenses                      Left 20/\_\_\_\_ Cor. To 20/-\_\_\_\_

**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 (print): \_\_\_\_\_



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

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

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

# Wheeling Jesuit University Student Pre-Entrance Immunization Requirement

**This Form Must Be Completed and Returned by July 15, 2008.**

An accurate record of immunizations is required as part of the admissions procedure for all 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 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 will not be permitted to attend classes or reside in residence halls without completing this form; with the exception of possibly needing to complete the last injections of the hepatitis B series.

**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 SHOULD 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.

\_\_\_\_\_ (PPD **PLACEMENT**) Tuberculosis Mantoux Test. [A Tine or Monovac are not accepted] 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.**

\_\_\_\_\_ (PPD **READ**) 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: Positive \_\_\_\_\_ Negative \_\_\_\_\_

If positive, please define treatment: \_\_\_\_\_

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_ (IPV or OPV) Polio Series

\_\_\_\_\_ (HBV) Hepatitis B #1 Vaccination

\_\_\_\_\_ (HBV) Hepatitis B #2 Vaccination – due 1 month after the 1<sup>st</sup> injection

\_\_\_\_\_ (HBV) Hepatitis B #3 Vaccination – due 6 months after the 1<sup>st</sup> injection

\_\_\_\_\_ (Menactra) Bacterial Meningitis Vaccination. **If you've had the Menomune Bacterial Meningitis vaccination prior to 2005, you will need to get the Menactra vaccination.**

\_\_\_\_\_ 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**