## Note to the Student:

Unless ALL required Immunizations and Physical Examination are submitted by June 1<sup>st</sup>, Fall or Dec 1 Spring, a HOLD will be placed on your student account.

## WESTFIELD STATE UNIVERSITY STUDENT HEALTH FORM

www.westfield.ma.edu/healthservices

IMPORTANT
Upload completed health forms on WSU Health Services website.

## SIDE 1 - TO BE FILLED OUT BY THE STUDENT

## REPORT OF MEDICAL HISTORY

Emergency Contact: Name/Relationship  Home Phone  Health Insurance Carrier (if possible send copy of card)  Policy Number  mergency: Permission is hereby granted for emergency medical treatment for my grants/Guardians.  Signature:  Parent or Legal Grant Gran	Business Phone  Business Phone  Card Holder Card Hold  minor. Every effort will be ma	Cell P	hone thdat
Emergency Contact: Name/Relationship  Home Phone  Health Insurance Carrier (if possible send copy of card)  Policy Number  Policy Number  Permission is hereby granted for emergency medical treatment for my granents/Guardians.  Signature:  Parent or Legal Grane Allergies: Insects, food etc.:  History of:  History of:  Please ch  Addiction  Alcoholism  Head Injury (Concussion)	Business Phone  Business Phone  Card Holder Card Hold  minor. Every effort will be made a cuardian (if student under 18)  eck applicable box below	Cell P  Cell P  der's Bir  de to co	hone thdat
Emergency Contact: Name/Relationship  Health Insurance Carrier (if possible send copy of card)  Policy Number  Policy Number  Policy Number  Policy Number  Parent for my garents/Guardians.  Signature:  Parent or Legal Garents/Guardians:  Parent or Legal Garents/Guardians:  Parent or Legal Garents/Guardians:  Please ch  History of:  History of:  Yes No  Addiction  Addiction  Alcoholism  Head Injury (Concussion)	Business Phone  Card Holder Card Hold  minor. Every effort will be ma  uardian (if student under 18)  eck applicable box belo	Cell P	hone thdat
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mergency: Permission is hereby granted for emergency medical treatment for my grants/Guardians.  Signature: Parent or Legal Grants Allergies: Insects, food etc.:  History of: Yes No History of: Addiction Addiction Alcoholism Alcoholism Alergies: Permission is hereby granted for emergency medical treatment for my grants and grant	minor. Every effort will be mauardian (if student under 18)  eck applicable box below	ow:	
Parent or Legal Go  EDICAL HISTORY: rug Allergies: Yes No If YES, list drug and reaction:  ther Allergies: Insects, food etc.:  History of: Yes No History of: Yes No Addiction Alcoholism Gastrointestinal Problems Alcoholism Head Injury (Concussion)	uardian (if student under 18)  eck applicable box belo	ow;	ontac
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Alcoholism Head Injury (Concussion)		1	INU
	Substance Use disorder		$\vdash$
	Surgery		$\vdash$
Asthma Hearing Deficit	Appendectomy		
Back injury/problem Heart Problems	Tonsillectomy		
Chickenpox: Date if known Hepatitis (A, B, C, D, E)	Other surgery-comment below		
Depression/Anxiety High Blood Pressure	Tobacco/Marijuana user		
Diabetes Kidney Problems	Any Non-prescribed drug use		<u> </u>
Disease/Injury of joints/bones Learning Disability	Tuberculosis or positive test	<del></del>	-
Ear, Nose, Throat Problems Mononucleosis	Thyroid Disease	<b></b>	+
			+-
			-
Eating Disorders Seizures  Eye Problems Sickle Cell Trait/Disease  Fainting Skin Condition:  Have you been hospitalized for mental health concerns? If yes, please write date	Cancer: date of dx and type Birth Control Menstrual Disorder e/place/reason for hospitaliza	tion.	

TO THE STUDENT: This information is confidential and subject to protection under HIPAA. The University will not be liable for any medical history information that is omitted from this form.

SREVIEW: Are there any abnormalities of the following?  Yes No  Ears, Nose or Throat 7. Genitourinary  Eyes 8. Musculoskeletal  Respiratory 9. Neuropsychiatric  Cardiovascular 10. Metabolic/Endocrine  Gastrointestinal 11. Lymph  Hernia 12. Skin	31-10-10-11			DOB:		
Tdap 1 dose in past 10 years  MMR 2 doses (given after 1st birthday and at least 28 days apart). Lab evidence of immunity acceptable  Varicella 2 doses (given after 1st birthday and at least 28 days apart). Lab evidence of immunity acceptable  Hepatitis B 3 doses. Lab evidence of immunity acceptable  Meningitis ACWY 1 dose required for all full-time students 21 years of age or younger and must be given after 16th birthday. (Meningitis b vaccine is not required and does not meet this requirement)  WSU HEALTH SERVICES RECOMMENDED IMMUNIZATIONS FOR COLLEGE  Meningitis B  Hepatitis A  HPV (Human Papilloma Virus)  Influenza (annual dose recommended in fall) Look for vaccine clinics on campus!  COVID up to date    COVID up to date	MASSACHUSETTS I	PH REQU	JIRED I	MMUNIZATIONS FOR CO	LLEGE	
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City: \_\_\_\_\_

Phone: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

License # & State: <u>Upload completed form on WSU Health Services website</u> QUESTIONS CALL 413-572-5415

Date: Printed Name: \_\_\_\_