THE COLLEGE OF WOOSTER

2021/22 STUDENT HEALTH INFORMATION FORM

Email completed form along with a copy of immunization record and copy of insurance card to student_wellness_center@wooster.edu. A physician physical is not required.

Last Name_________________________________ First Name _________________________________ Middle Name ______________________

Date of Birth __________________________________

Gender Identity: ________________________________ Sex assigned at birth: Male _____ Female _____ Other _____

Home Address____

Street City State Zip Country

Home Phone Number____ **Student Cell Phone Number** __________________________________

Emergency Contact #1: Name/Relationship ____ Phone # ____________________________

Emergency Contact #2: Name/Relationship ____Phone # ___________________________

Family History	Age	Occupation	State of Health	If Deceased, Cause	Have any of your relatives had any of the following? If Yes / Relationship	
Parent 1					Tuberculosis	
Parent 2					Diabetes	
Brother (s)					Kidney Disease	
					Heart Disease	
					Hereditary Disease	
Sister (s)					Psychiatric Illness	
					Epilepsy, Seizure	
					Alcohol/Drug	
					Cancer (type)	

_____ I AM ADOPTED AND DON'T KNOW MY FAMILY HISTORY. _____ I AM ADOPTED AND DO KNOW MY FAMILY HISTORY

IMMUNIZATIONS -

Recommended Immunizations (For more information see http://www.acha.org/documents/resources/guidelines/ACHA_RIPI.pdf**)**

MMR (Measles, Mumps, Rubella) Dose 1 (Given at age 12 months or later) Date: ____________________________

MMR dose 2 (Given at least 28 days after first dose) Date: __________________________________

Tetanus (Within the last 10 years) Date: _________________________ **Type of booster: Td** _____ **Tdap** _____

Covid-19 Vaccine Dose 1 Date: ___________________ **Dose 2 Date:** ___________________ **Manufacturer:** __________________________

Send a copy of your complete immunization record and a copy of insurance card along with the Health Form.

Longbrake Student Wellness Center • 570 E. Wayne Ave. Wooster, Ohio 44691
Telephone (330) 263-2319 • Fax (330) 263-2369 • www.wooster.edu

STUDENT NAME ___________________________________

List any **MEDICATIONS** **you currently take** with dosage and how often taken (include over the counter meds, contraceptives, and herbal drugs or supplements):	
1.	5.
2.	6.
3.	
4.	
ALLERGIES _____NO _____YES Please list allergies to: Medications, Food and Environmental – include type of reaction	
1.	3.
2.	4.

Personal History

Please answer all questions. Indicate Age of onset and Comment on all "yes" answers (attach additional information if applicable).

Have you had Covid-19? No ____ Yes, Date: ________________________

HAVE YOU HAD?	NO	Yes	If Yes, Explain	HAVE YOU HAD?	NO	Yes	If Yes, Explain
Anemia				Learning Disability			
Anxiety				Meningitis			
Asthma				Mononucleosis			
Attention Deficit Disorder				Orthopedic problems			
Dyslexia				Pneumonia			
Bipolar				Recurrent Headache			
Back Problems				Rheumatic Fever			
Cancer				Scarlet Fever			
Ear, Eye, Nose, Throat Prob				Seizure			
Depression				Sickle Call trait/disorder			
Diabetes				Sinusitis			
Eating Disorder				Skin Problem			
Hay Fever				Sleeping problems			
Hearing Loss				Stomach/Intestinal			
Heart Disease				Surgeries/Hospitalizations			
Hepatitis				Thyroid problems			
High Blood Pressure				Tuberculosis			
Joint problems				Urinary Tract Infections			
Kidney problems				Other			

******If you have a significant health problem please attach records from home physician.***

If you plan to get allergy shots at The College of Wooster, please send instructions and serum from home allergist.
Have you received treatment/counseling for mental health related issues? Yes___ No___
Do you use a medically required device? (If yes, please list.) Yes___ No___ ____
Concussion? Yes___ No___ How many times? ______
*Are you currently trained as: EMT___ First Responder___

STATEMENT OF AUTHORIZATION

I authorize and request The College of Wooster Longbrake Student Wellness Center to administer outpatient and inpatient, medical, surgical services and immunizations and to perform emergency procedures, as necessary, or to refer to duly licensed medical personnel when indicated, including transfer to outside hospitals.
I also authorize the release of my Social Security Number for medical and/or insurance purposes while at The College of Wooster. For specific information, a release is required per case.
I authorize the release of my name and DOB to Cleveland Clinic as proof of treatment to track CCF physician's workload. I understand that no other information about treatment will be shared from this release.

Signature of Student____ Date ________________

Signature of Parent or Guardian (If under legal age 18 of adulthood in Ohio) ____________________________________Date_____________