PACIFIC LUTHERAN UNIVERSITY

Health Center

Medical History Record

Tacoma WA 98447-0003
Phone 253-535-7337
FAX 253-536-5042

◆ **This form must be completed and submitted to the Health Center for attendance. This form has 3 pages.**

Last Name	**First Name**	**Middle Initial**	**Date of Birth** (M / D / Y)

Gender at Birth _____ **Preferred Gender** _____	**Social Security Number** - -

Student ID	**Telephone Number (Home)**	**Telephone Number (Mobile)**

Home Address

Street	**City**	**State or Province**	**ZIP or Postal Code**	**Country**

Emergency Contact (in U.S.)	**Relationship**		**Telephone Number**
Are you a former PLU Student?	☐ **Yes** ☐ **No**	**If yes, when?**	**Previous Name**
Are you an international student or visiting scholar?	☐ **Yes** ☐ **No**	**If yes, which country are you from?**	

In what term will you enter PLU?	☐ **Fall** ☐ **Spring** ☐ **J-Term** ☐ **Summer**	**Of what year?**	☐ **2017** ☐ **2018** ☐ **2019** ☐ **2020**	

Insurance Information

Do you have medical and hospital coverage?	☐ **Yes** ☐ **No**	**If yes, what is the name of the person who carries the coverage?**
Name of Insurance Carrier	**ID Number**	**Group Number**

1. Health Center Consent and Release

This document has legal significance; please read it carefully.

Pacific Lutheran University (PLU) offers medical services to all of its' full- and part-time students. This form is required for attendance.

PLU will keep your medical records confidential, and they will only be used for the provision of health care services Because of PLU's promise of confidentiality, you, as the student, must inform Residence Hall staff or other university personnel (i.e. physical education instructors or athletic coaches) of any medical condition that you have that could be of concern while you are attending PLU. Furthermore, you are responsible for wearing a Medic Alert bracelet, necklace, or similar device to warn health care providers of your diabetes, hemophilia, heart disease, seizure disorder, drug allergies, or other significant medical conditions.

In the event that PLU is required to rely on this consent to authorize necessary medical care and treatment for the student, the undersigned, individually and jointly, agree to indemnify and hold PLU harmless for the costs incurred for said emergency care and treatment, including reasonable attorney's fees and costs incurred in defending and/or instituting a suit to recover said medical expenses.

As a PLU student, I consent to any necessary medical or surgical treatment in the event of a medical emergency as confirmed by any attending physician, advanced registered nurse practitioner, or physician assistant at PLU Health Services. If the student is under 18 years of age, PLU will attempt to contact the undersigned parent or guardian for approval before relying on this consent. In addition, the undersigned student must personally consent to said medical procedure if he or she is physically and emotionally capable of consenting at the time such treatment is required.

Student Signature Please print and sign your name	**Date**
Parent or Guardian Signature Required if the student is under 18 years of age	**Date**

This form was completed by: Student ☐ Parent ☐ Other_____

Last Name	First Name	Middle Initial	Student ID

2. Immunization Record

You will not be permitted to register without proof of immunizations on record at the PLU Health Center. Places to look for official immunization documents include your high school, primary care provider's office, parent's official records, and military records. If you are unable to locate this information, we are able to offer you immunizations at the Health Center at reduced cost. Please call us at 253-535-7337 or send email to health@plu.edu for an appointment.

If you were born prior to 1 January 1957, you are considered immune due to exposure to these diseases, and you are not subject to the immunization requirements.

For all other students:

1. **Rubeola (Measles)**
   One of the following must be provided
   a. Documentation of two immunizations with live attenuated virus vaccine **after the student's first birthday** and **administered at least 30 days apart**. Persons vaccinated with an inactivated (killed) virus or an unknown vaccine prior to 1968 must be revaccinated.
   b. Documented history of measles disease
   c. Documented laboratory evidence of immunity to rubeola

2. **Mumps**
   One of the following must be provided
   a. Documentation of immunization **after 1967** and **after the student's first birthday**
   b. Documented history of mumps disease
   c. Documented laboratory evidence of immunity to mumps

3. **Rubella (German Measles)**
   One of the following must be provided
   a. Documentation of vaccination with a live virus vaccine **after 1969** and **after the student's first birthday**
   b. Laboratory evidence of immunity to rubella

Immunizations **Required** for All Students. **You may also attach copies of official records.**

Measles, Mumps, and Rubella (MMR)	Date of 1st Vaccine	◆ **OR**	**Measles**	Date of 1st Vaccine
Measles, Mumps, and Rubella (MMR)	Date of 2nd Vaccine			Date of 2nd Vaccine
			Mumps	Date of Vaccine
			Rubella	Date of Vaccine

Certification	This section must be completed by a health care provider, **or** you may attach copies of official records			
Signature of Healthcare Provider	☐ **DO** ☐ **MA** ☐ **NP** ☐ **LPN** ☐ **MD** ☐ **RN**		**Telephone Number**	**Date**

Immunizations **Recommended** for All Students

Tetanus Date of Last Vaccine ☐ **Td** ☐ **TdAP**		**Hepatitis B 1** Date of 1st Vaccine	**Hepatitis B 2** Date of 2nd Vaccine	**Hepatitis B 3** Date of 3rd Vaccine
Hepatitis A 1 Date of 1st Vaccine	**Hepatitis A 2** Date of 2nd Vaccine	**HPV 1** Date of 1st Vaccine	**HPV 2** Date of 2nd Vaccine	**HPV 3** Date of 3rd Vaccine
Meningococcal Date of vaccine	**Varicella (Chickenpox)** Date of vaccine, disease, or titer		☐ **Vaccine** ☐ **Disease** ☐ **Titer**	

Polio 1 (OPV/IPV) Date of 1st Vaccine	**Polio 2** Date of 2nd Vaccine	**Polio 3** Date of 3rd Vaccine	**Polio 4** Date of 4th Vaccine

Last Name	First Name	Middle Initial	Student ID

3. Medical History

Asthma	☐ **Yes** ☐ **No**	◆ If yes, when did it start?
Diabetes	☐ **Yes** ☐ **No**	◆ If yes, what type and when did it start?
Depression/Anxiety	☐ **Yes** ☐ **No**	◆ If yes, when did it start?
Eating disorder	☐ **Yes** ☐ **No**	◆ If yes, what type and when did it start?
Heart disease	☐ **Yes** ☐ **No**	◆ If yes, what type and when did it start?
Seizure disorder	☐ **Yes** ☐ **No**	◆ If yes, what illness when did it start?
Other chronic illness	☐ **Yes** ☐ **No**	◆ If yes, what illness when did it start?
Have you ever been hospitalized or had surgery?	☐ **Yes** ☐ **No**	◆ If yes, what type of hospitalization or surgery, and when?
Do you take any medications regularly? Please include vitamins and supplements.	☐ **Yes** ☐ **No**	◆ If yes, what medication(s), dosage and how often?
Do you smoke	☐ **Yes** ☐ **No**	◆ If yes, when did you start smoking?

4. Allergies

Any drug or medicine	☐ **Yes** ☐ **No**	◆ If yes, what type of drug and reaction?
Any food	☐ **Yes** ☐ **No**	◆ If yes, what type of food and reaction?
Insect stings or bites	☐ **Yes** ☐ **No**	◆ If yes, what type of bite or sting and reaction?

5. Family History

Do any of your blood relatives have any of the following?
Please specify parents, siblings, maternal grandparents or paternal grandparents.

Diabetes	☐ **Yes** ☐ **No**	◆ If yes, what type of diabetes and who?
Stroke	☐ **Yes** ☐ **No**	◆ If yes, who?
Heart attack before age 50	☐ **Yes** ☐ **No**	◆ If yes, who?
High blood pressure	☐ **Yes** ☐ **No**	◆ If yes, who?
Alcohol problems	☐ **Yes** ☐ **No**	◆ If yes, who?
Cancer	☐ **Yes** ☐ **No**	◆ If yes, what type of cancer and who?

Please return this form to: Pacific Lutheran University Health Center, Tacoma WA 98447-0003