PACIFIC LUTHERAN UNIVERSITY

HEALTH CENTER

12180 Park Avenue South
Tacoma, Washington 98447-0003

Phone: 253-535-7337
Fax: 253-536-5042
Email: health@plu.edu

Medical History Record

THIS FORM IS REQUIRED FOR ATTENDANCE

Documents may be sent securely via fax or through our secure ETRIEVE site: https://etcentral.plu.edu/#/form/24

PACIFIC LUTHERAN UNIVERSITY OFFERS MEDICAL SERVICES TO ALL STUDENTS, FULL OR PART TIME.

Last Name	**First Name**	**Middle Initial**	**Preferred Name**

Date of Birth (MM/DD/YYYY)	**Gender Assigned at Birth** ❑ Female ❑ Male	**Gender Identity** ❑ Female ❑ Male ❑ Trans ❑ Nonbinary ❑ Other:	**Social Security Number**

PLU Student ID	**Telephone Number (Home)**	**Telephone Number (Mobile/Cell)**

HOME ADDRESS

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

Name of Emergency Contact (in U.S.)	**Emergency Contact Telephone Number**	**Emergency Contact Relationship**

Are you an International Student?	❑ Yes ❑ No	**If yes, which country are you from?**
Which program are you enrolled in?	❑ Undergrad ❑ International program ❑ MBA ❑ Visiting Scholar ❑ Pathway International	
Are you a former PLU student?	❑ Yes ❑ No	**If yes, what year did you attend?** **What was your previous last name?**
In what term will you enter PLU?	❑ Fall ❑ J-Term ❑ Spring ❑ Summer	
Of what year?	❑ **2022** ❑ **2023** ❑ **2024**	

INSURANCE INFORMATION

Do you have medical and hospital coverage?	❑ Yes ❑ No	**PLEASE ATTACH A COPY (FRONT & BACK) OF YOUR INSURANCE CARD**

1. Health Center Consent and Release

This document has legal significance - please read it carefully.

Pacific Lutheran University (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 Name**	**Date**
Parent or Guardian Signature Required if the student is under 18 years of age	**Please Print Name**	**Date**

Last Name	First Name	Middle Initial	Student ID

2. Immunization Record *- You may also attach copies of vaccines or lab results as official records.*

***** You will not be permitted to register for classes without proof of 2 MMR's and, as of 4-26-21, COVID vaccines or COVID Exemption form.***

Exemption forms can be located on our website
www.plu.edu/chws/documents
under "Health Forms"

- Places to look for official immunization documents include your high school, primary care provider's office, parent's official records, your Public Health Department, and military records.
- If you are unable to locate this information, we are able to offer you immunizations and titer blood draws at the Health Center at a reduced cost. Please call the Health Center at 253-535-7337.
- If you were born **prior to 1 January 1957**, you are considered immune to the MMR due to exposure to these diseases, and you are not subject to the immunization requirements.
- **For all other students:**
  - A. **Rubeola (Measles) -** One of the following must be provided:
    1. 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.
    2. Documented history of measles disease
    3. Documented laboratory evidence of immunity to rubeola
  - B. **Mumps -** One of the following must be provided:
    1. Documentation of immunization after 1967 and after the student's first birthday
    2. Documented history of mumps disease
    3. Documented laboratory evidence of immunity to mumps
  - C. **Rubella (German Measles) -** One of the following must be provided:
    1. Documentation of vaccination with a live virus vaccine after 1969 and after the student's first birthday
    2. Laboratory evidence of immunity to rubella

REQUIRED IMMUNIZATIONS FOR ALL STUDENTS:

Measles, Mumps, and Rubella (MMR)	Date of 1st Vaccine Date of 2nd Vaccine	**OR**	**Measles**	Date of 1st Vaccine Date of 2nd Vaccine
OR **MMR Titer results**	❑ **Positive** ❑ **Negative** Date of Titer:		**Mumps**	Date of Vaccine
			Rubella	Date of Vaccine

COVID-19	Date / Name of 1st Vaccine	Date / Name of 2nd Vaccine

Signature of Healthcare Provider	❑ MA ❑ DO ❑ LPN ❑ RN ❑ NP/ARNP ❑ MD	**Telephone Number**	**Date**

RECOMMENDED IMMUNIZATIONS 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** Date of 3rd Vaccine

Adult Polio (OPV/IPV) Date of Vaccine	**Varicella (Chickenpox)** Date of 1st Vaccine Date of 2nd Vaccine ❑ **Disease** ❑ **Titer**	**Meningococcal (MCV)** Date of 1st Vaccine Date of 2nd Vaccine	**MEN B** Date of 1st Vaccine Date of 2nd Vaccine

COVID-19 Booster	Date / Name of 1st Booster	Date / Name of 2nd Booster

Last Name	First Name	Middle Initial	Student ID

3. Medical History		*Please Mark Yes or No*
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, diagnosis and start date?
Mental health diagnosis	❑ Yes ❑ No	If yes, diagnosis and start date?
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 or vape?	❑ Yes ❑ No	If yes, when did you start smoking? Vaping?
Have you been diagnosed with COVID-19?	❑ Yes ❑ No	If yes, when?
Autism Spectrum	❑ Yes ❑ No	If yes, diagnosis and start date?
Mental Health Counseling / Therapy	❑ Yes ❑ No	If yes, what is your plan for continued care?

4. Allergies		*Please Mark Yes or No*
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.
		Please Mark Yes or No
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?
Mental Health Diagnosis	❑ Yes ❑ No	If yes, diagnosis and for whom?