



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 <input type="checkbox"/> Female <input type="checkbox"/> Male	Gender Identity <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Trans <input type="checkbox"/> Nonbinary <input type="checkbox"/> 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?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which country are you from?			
Which program are you enrolled in?		<input type="checkbox"/> Undergrad <input type="checkbox"/> International program <input type="checkbox"/> MBA <input type="checkbox"/> Visiting Scholar <input type="checkbox"/> Pathway International			
Are you a former PLU student?		<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what year did you attend? What was your previous last name?			
In what term will you enter PLU?		<input type="checkbox"/> Fall <input type="checkbox"/> J-Term <input type="checkbox"/> Spring <input type="checkbox"/> Summer			
Of what year?		<input type="checkbox"/> 2022 <input type="checkbox"/> 2023 <input type="checkbox"/> 2024			
INSURANCE INFORMATION					
Do you have medical and hospital coverage?		<input type="checkbox"/> Yes <input type="checkbox"/> 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.

PLU's Health Center may share health information with PLU's Office Of Accessibility & Accommodation (OAA) so that OAA can partner with you to establish reasonable accommodations and services.

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 - ** PLEASE NOTE: Your provider's office does not need to sign the form if you 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	OR	Measles	Date of 1st Vaccine
	Date of 2nd Vaccine		Mumps	Date of 2nd Vaccine
OR MMR Titer results	<input type="checkbox"/> Positive <input type="checkbox"/> Negative Date of Titer:		Rubella	Date of Vaccine
COVID-19	Date / Name of 1st Vaccine		Date / Name of 2nd Vaccine	
Signature of Healthcare Provider		<input type="checkbox"/> MA <input type="checkbox"/> DO <input type="checkbox"/> LPN <input type="checkbox"/> RN <input type="checkbox"/> NP/ARNP <input type="checkbox"/> MD	Telephone Number	Date

RECOMMENDED IMMUNIZATIONS FOR ALL STUDENTS

Tetanus	<input type="checkbox"/> Td	Hepatitis B 1	Hepatitis B 2	Hepatitis B 3
Date of Last Vaccine	<input type="checkbox"/> TdAP	Date of 1st Vaccine	Date of 2nd Vaccine	Date of 3rd Vaccine
Hepatitis A 1	Hepatitis A 2	HPV 1	HPV 2	HPV
Date of 1st Vaccine	Date of 2nd Vaccine	Date of 1st Vaccine	Date of 2nd Vaccine	Date of 3rd Vaccine
Adult Polio (OPV/IPV)	Varicella (Chickenpox)	Meningococcal (MCV)	MEN B	
Date of Vaccine	Date of 1st Vaccine Date of 2nd Vaccine	Date of 1st Vaccine	Date of 1st Vaccine	
	<input type="checkbox"/> Disease <input type="checkbox"/> Titer	Date of 2nd Vaccine	Date of 2nd Vaccine	

Last Name	First Name	Middle Initial	Student ID

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

3. Medical History		Please Mark Yes or No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did it start?
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type and when did it start?
Depression / Anxiety	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, diagnosis and start date?
Mental health diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, diagnosis and start date?
Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type and when did it start?
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type and when did it start?
Seizure disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what illness, when did it start?
Other chronic illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what illness, when did it start?
History of hospitalization for Mental or physical health concerns or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of hospitalization or surgery, and when?
Do you take any medications regularly? Please include vitamins and supplements.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what medication(s), dosage and how often?
Do you smoke or vape?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when did you start smoking? Vaping?
Have you been diagnosed with COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, when?
Autism Spectrum	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, diagnosis and start date?

4. Allergies		Please Mark Yes or No
Any drug or medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of drug and reaction?
Any food	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of food and reaction?
Insect stings or bites	<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of diabetes and who?
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
Heart attack before age 50	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
Alcohol problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, who?
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type of cancer and who?
Mental Health Diagnosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, diagnosis and for whom?