



STUDENT HEALTH RECORD

For confidential consideration, please send this in the separate envelope provided to:

Warren Wilson College
 Health Center - WWC #6256
 P.O. Box 9000
 Asheville, NC 28815-9000
 FAX 828-298-2225

You will not be allowed to register for classes until this record is received by the health center. This information will be kept in confidence.

Student's Name: _____ Date of Birth: _____
first middle last (mm/dd/yyyy)

Parent/Guardian's Name: _____ Sex: _____

Address: _____ Status: First Year _____ Transfer _____
city state zip

Parent/Guardian's Telephone: () _____ Date: _____

Insurance Company Name: _____ Policy #: _____

Policyholder's Name: _____

The following health history is confidential, does not affect your admission status and may only be shared with other health care professionals on an as needed basis to ensure that the student receives required and/or requested treatment and care as necessary. Please attach additional sheets for any items that require fuller explanation.

FAMILY AND PERSONAL HEALTH HISTORY (Print in black ink) To be completed by student

Has any person related to you by blood, had any of the following?

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
High blood pressure				Cholesterol or blood fat disorder				Alcoholic/drug problems			
Stroke				Diabetes				Psychiatric illness			
Heart Attack before age 55				Glaucoma				Suicide			
Blood or clotting disorder				Cancer (type)				Other			

Have you ever had or have you now: (please check at right of each item and if yes, indicate year of first occurrence)

	Yes	No	Year		Yes	No	Year		Yes	No	Year		Yes	No	Year
High blood pressure				Hay fever				Jaundice or hepatitis				Kidney stone			
Rheumatic fever				Allergy injection therapy				Rectal disease				Protein or blood in urine			
Heart trouble				Arthritis				Severe or recurrent abdominal pain				Hearing loss			
Pain or pressure in chest				Concussion				Hernia				Sinusitis			
Shortness of breath				Frequent/severe headaches				Easily fatigued				Severe menstrual cramps			
Asthma				Dizziness or fainting spells				Anemia or Sickle Cell Anemia				Irregular periods			
Pneumonia				Severe head injury				Eye trouble other than glasses/contacts				Sexually transmitted disease			
Chronic cough				Paralysis				Bone or joint deformity				Blood transfusion			
Head or neck radiation treatment				Disabling depression				Knee problems				Alcohol use			
Tumor or cancer (specify)				Excessive worry or anxiety				Recurrent back pain				Drug use			
Malaria				Ulcer				Neck injury				Anorexia/Bulimia			
Thyroid trouble				Intestinal trouble				Back injury				Smoke 1+ pack cigarettes/weekly			
Diabetes				Pilonidal cyst				Broken bone (specify)				Regular exercise			
Serious skin disease				Frequent vomiting				Kidney infection				Wear seat belt			
Mononucleosis				Gall bladder trouble or gallstones				Bladder infection				Other (specify)			

Please list any drugs, medicines, birth control pills, vitamins, and minerals (prescription and nonprescription) you use and indicate how often you use them.

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

Name _____ Use _____ Dosage _____ Name _____ Use _____ Dosage _____

IMMUNIZATION RECORD (Please print in black ink). To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.				
Last Name			First Name	Middle Name
			Date of Birth (mm/dd/yyyy)	Social Security Number

SECTION A: REQUIRED IMMUNIZATIONS / These immunizations are required by North Carolina State Law.
For further information, please visit the website.

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
•DTP or Td (series of three required)				
•Tdap Booster (at least 1 within last 10 years)				
• Polio (series of three required)				
•MMR (series of 2 required after first birthday as a combination shot) OR...				
•Measles (after first birthday) TWO DOSES REQUIRED			Disease Date	Titer Date & Result
•Mumps TWO DOSES REQUIRED			Disease Date	Titer Date & Result
•Rubella ONE DOSE REQUIRED			Disease Date Not Accepted	Titer Date & Result
Hepatitis B (Series of 3 required if DOB is after July 1, 1994)				

•Tuberculin (PPD) Test (applied mm/dd/yyyy) (required within 12 months prior to the first day of classes)	Date read mm induration
Chest x-ray, if positive PPD	Date Results
Treatment, if applicable	Dates

The CDC recommends college students, especially freshman living in dormitories, receive the meningococcal vaccine. I choose to decline the meningococcal vaccine. _____ (initial here to decline or place date in blank below indicating date vaccine was given.)

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
Meningococcal				

SECTION B: RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain departments (i.e. health sciences).

	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy	mm/dd/yyyy
Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	Titer Date & Result
Gardasil (series of 3)				
Other				

Signature or Clinic Stamp REQUIRED

Signature of Provider _____ Date _____

Print Name of Provider, Address, and Phone Number _____

FAMILY AND PERSONAL HEALTH HISTORY-CONTINUED (Please print in black ink) **To be completed by student**

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the experience has occurred more than once.

Adverse Reactions To:	Yes	No	Explanation
Penicillin			
Sulfa			
Other antibiotics (name)			
Aspirin			
Codeine			
Other pain relievers			
Other drugs, medicines, chemicals (specify)			
Insect bites			
Food allergies (name)			
	Yes	No	Explanation
Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)			
Have you ever been a patient in any type of hospital? (Specify when, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (explain)			
Is there loss or seriously impaired function of any organs? (Please describe)			
Other than for a routine check up, have you seen a physician or health-care professional in the past six months? (describe)			
Have you ever had any serious illnesses or injuries other than those already noted? (Specify when and where and give details)			

IMPORTANT INFORMATION...PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN IF STUDENT UNDER AGE 18)

- A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter's) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.
- B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service.
- C) I hereby authorize Warren Wilson College to use information supplied within this document for aggregate data collection purposes. No identifying information will be used.

Signature of Student _____ Date _____

Signature of Parent/Guardian, if student is under age 18 _____ Date _____

PHYSICAL EXAMINATION

Last Name	First Name	Middle Name	Date of Birth (mm/dd/yyyy)
Permanent Address: street, city, zip code			Area code/phone number

Urinalysis:	Sugar:	Albumin:	Micro:	If indicated: Hgb/Hct:
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Blood Pressure _____ Pulse _____ Height _____ Weight _____

System examined	Normal	Abnormal	Comments
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Abdominal/hernia			
Genitourinary			
Metabolic/Endocrine			
Neuropsychiatric			
Upper extremity joints			Inclusive of: shoulder, elbow, wrist
Lower extremity joints			Inclusive of: hip, knee, ankle
Spine and musculature			
Skin			
Mammary			
Reflexes			
Other			

Any impairment of vision: glasses / contact lens / other impairment: _____

Is student under treatment for any medical or emotional condition? Yes _____ No _____

Explain _____

I certify that I have reviewed the medical history and examined the above student and I recommend:

_____ clearance with no limitations for Physical Education/Outdoor Education/Athletics/Intramurals

_____ clearance pending further evaluation or testing (please explain)

_____ referral to other health care professional prior to clearance (please explain) _____

_____ clearance with limitations (please explain) _____

_____ disqualified from _____ (identify what student is disqualified from)

Please explain reason for disqualification _____

_____ medical follow-up recommended for _____

_____ mental health follow-up recommended: specify: counseling/psychiatrist/psychologist _____

Name of examining MD, PA, or LNP _____ Signature _____

Address _____ Phone _____

_____ Date of Examination _____