WASHINGTON ADVENTIST UNIVERSITY HEALTH SERVICE PRE-ENTRANCE REQUIREMENTS AND HEALTH SERVICE DOCUMENTS

Health Services endeavors to accommodate any health care needs you may have during your stay at Washington Adventist University. The required documentation contained on the following pages serves a twofold purpose: (1) to comply with federal and state recommendations, and (2) to promote good health for our students.

All students enrolled for six or more credit hours must submit these documents <u>before</u> the beginning of the first semester of attendance at WAU. Submit completed forms to the Health Service office, Wilkinson Hall basement, Room 13, or through intercampus mail. You can also mail or fax completed forms. Address and fax numbers are listed on the Medical History form.

PRE-ENTRANCE HEALTH REQUIREMENTS

	The following documents must be submitted before registration.
	Medical History . This is to be filled out by the student. Answer all questions fully on thi enclosed form.
	Physical Examination. This is to be performed by the physician (or other authorized health care provider). This exam must have been done within the previous 12 months. It is strongly preferred that the enclosed form be submitted. If another form is used, it should contain all of the same information that is on this form.
	Immunization Record. This record should show the dates the student received the listed vaccines and must be signed and dated by the appropriate health care provider. See the enclosed form for additional instructions. If you cannot locate part or all of your records, free or low cost resources may be available to you. Contact Health Service for this information.
	Authorization to Treat Minors. This form <u>must</u> be completed for all students under the age of 18. The Authorization Form is enclosed and located under the Immunization Record.
	Accident Insurance. This insurance is provided by WAU for all traditional students registered for six or more credit hours. It is the responsibility of the student to process any claims, and forms are available in the Health Service office.
<u> </u>	Sickness insurance. Students enrolled for six or more credit hours may purchase this insurance. To purchase sickness insurance, a WAU Insurance Enrollment Form must be submitted at the beginning of each school year or whenever coverage is desired. This coverage must be renewed annually. Students <u>not</u> purchasing insurance <u>must</u> submit an Insurance Waiver Form each year. These forms are available in the Health Service Office.
<u> </u>	Foreign Student Sickness Insurance. International students on an F-1 visa are required to have sickness insurance coverage. This can be obtained as outlined above. Another policy can be substituted if valid proof of coverage is presented to the Office of

Health Services. Additionally, an Insurance Waiver Form must be submitted yearly.

Health Service 7600 Flower Ave. Takoma Park, MD 20912 Phone 301-891-4009 Fax 301-891-4115 Wilkinson Hall Rm. 13 www.wau.edu

WASHINGTON ADVENTIST UNIVERSITY PRE-ENTRANCE HEALTH REQUIREMENTS

Please type or print legibly and answer completely. Physical exams and lab work must have been done within the previous 12 months. Attach any required supporting documents as needed. All information is confidential, not to be released without permission.

Date:	Sex: Male / Female	Class: Fr, So, Jr, Sr,		Major:			
Name: First,		Birth Date:	Age:	ID/Soc.Sec.#			
Last, First,	, Middle I.			ID/Soc.Sec.#			
Emergency Notification:		<u></u>	_				
School Address	Name		Р	Phone Number hone Number			
Home Address			P	hone Number			
Marital Status (circle): Single Married	Divorced/Widowed	Religious Prefere	ence:				
MEDICAL HISTORY							
	(To be com	pleted by student)					
1. Allergies: Medicines		Foods_					
Other							
2. List and date past major surgeries:							
Hospitalizations							
Serious Illness/Accidents							
Contagious Diseases							
- -							
Special diets/other		<u> </u>		· · · · · · · · · · · · · · · · · · ·			
3. Please indicate which of your blood re	elatives have/have had:		•				
High blood pressure	Stroke	Diabetes		Mental illness			
Heart disease	Cancer	Ulcers		Other			
4. Please indicate the year you have had							
Ears, Nose, Throat	Freq. Vomiting		Fain	iting spells			
Hearing difficulties	_ Freq. Indigestion			Muscular/Skeletal			
Sinus infections	Ulcers			ere back pain			
Freq. sore throats/colds		-		/swollen joints			
Eyes	Diarrhea/constipation		Arth				
Loss of vision	Kidney dysfunction	to/Urinary	Bon	e deformities			
Wear glasses/contacts	Freq. urinary tract in:	Fact	Carre	Skin			
Respiratory Asthma	Menstrual difficulty		Ecze	ere acne			
Tuberculosis	Severe cramps			riasis			
Other	_ Severe cramps Irregular menstrual c			er persistent rash			
<u>Cardiovascular</u>	Pregnancy	ycle		nge in mole			
Heart attack		docrine	Chai	Emotional			
Heart disease	Under/Overactive thy		Carre	· · · · · · · · · · · · · · · · · · · 			
Hypertension	Diabetes	yroid		<i>i</i>			
Clotting abnormality		rological		mpted suicide			
Anemia	Seizures Neu	IOIOERAI		er Psych. Care			
Gastrointestinal	Epilepsy			stance obuga			
Freq. Abdominal Pain	Severe headaches			d counseling			

N	am	e.

Date:

PHYSICAL EXAMINATION

(To be completed by health care provider)

Height	Weight	Blood Pressure	Eyes/Vision R	L		
	Normal	Abnormal	Remarks			
Ears/Hearing						
Nose			<u></u>			
Mouth/Throat						
Teeth						
Neck						
Chest						
Heart						
Lungs						
Abdomen						
Back/Extremities						
Neurological						
Skin						
Genito, uro, rectal (if ind	icated)					
Comments/Recommenda	tions:	-				
Does the student have a program? Explain: Does the student have an				3 a Tuli academic		
Print Name:	Print Name: Signature: Phone: Phone:					
Address: (Health C				·		
TB Test		Laboratory Tests				
<u>Tuberculin Testing</u>	Complete Bl		Urine Analysis			
Date given	Hemoglo	bin	Glucose			
Date read	WBC		Albumin			
Results	RBC		Ph			
Chest X-ray if indicate	ed: Other Te	sts, Abnormals	Color/Character	Color/Character		
		<u> </u>				

Name:			··-				
	•	IM	MUNIZAT	ION REC	ORD		
examining heal the student has	e legibly below the care provider in acquired immunitial and state guide	he dates the foll s not the person w ry through having	owing immuniz /ho administered had a particular	ations were gively attack to the state of th	ven. Attach supporti ss verified by a healt	ing documents th care provider,	(photocopies) if a statement that
TD (to MMR closer Polio Menio Hepat usuall	(measles, mumps together than one - Series usually gingococcal (meningitis B- Given to acy given 6 months) - Given in adulth , and rubella) - Tv month.) Persons ven in infancy and gitis) - Required b lults in three dose later, but no soon - Immunity can be	wood every ten yowo doses are need born before 195 dichildhood. By the state of Mass. The 2nd dose er than 2 months	ears after initial eded in childhood 7 are considered aryland by stude is given one most after the 2nd design of the 2nd	childhood DTP seried (no earlier than 12 immune. ents in on campus hoonth after the 1st dose	months of age of using unless a wee. The 3rd dose is	aiver is signed. s
			Date of	Vaccines			
Dose	DTP	TD*	Polio	MMR*	Meningococcal	Hep. B**	Varicella**
No.	<u> -</u>			-		· · · · · · · · · · · · · · · · · · ·	
2				 			
3 4	<u> </u>		`				
4	<u> </u>						
	Disease		- •	GG Only Results	e students, recomme	Immune	
2 2000						Yes No	
1							
2							
						·	
Signa	ture of health care	provider (admini	stration/verificat	tion)		Ľ	Pate
age: I hereby a to perform upo examination, n contact me by p rendered to my	uthorize and give on or administer to nedicines, vaccine phone or mail price	signed by parent/ consent to the hea my son/daughter s or anesthetics. It or to the use of this hout his/her conse	guardian and nath that the authorities of the event of any sauthorization. In tunless unable	otarized by a r r any licensed h y major medical It is not intended	at MINORS notary public, if the ealth care provider of any necessary med or surgical problem that any of the above esciousness, etc.). The	of Washington A lical or surgical i, the University we mentioned ser	dventist University treatment, will attempt to vices will be
Name (Print) Address			SignaturePhone				Date
Witness (Print))			Sign	ature		