Note to the Student:
Unless **ALL** required **Immunizations** and **Physical Examination** are submitted by July 1st, Fall or Dec 1 Spring, a HOLD will be placed on your student account.

WESTFIELD STATE UNIVERSITY
STUDENT HEALTH FORM

www.westfield.ma.edu/healthservices

SIDE 1 - TO BE FILLED OUT BY THE STUDENT

IMPORTANT
Mail Health Forms to:
WSU Health Services
P.O. Box 1630
Westfield, MA
01086-1630

REPORT OF MEDICAL HISTORY

PLEASE PRINT Complete before going for your physical examination.

Name: Last First M.I. Student ID# A… Year of Grad Date of Birth

Gender Identity:_____ Chosen Name: _____ Preferred Pronouns: _____

Home Address: Street City State Zip Home Phone Cell Phone

Emergency Contact: Name/Relationship Home Phone Business Phone Cell Phone

Emergency Contact: Name/Relationship Home Phone Business Phone Cell Phone

Health Insurance Carrier (if possible send copy of card) Policy Number Card Holder Card Holder's Birthdate

Emergency: Permission is hereby granted for emergency medical treatment for my **minor**. Every effort will be made to contact Parents/Guardians.

Signature: _____
Parent or Legal Guardian

MEDICAL HISTORY:

Drug Allergies: Yes____ No____ If YES, list drug and reaction:_____

Other Allergies: seasonal, insects, foods etc.: _____

Please check yes or no on each line.

History of:	Yes	No	History of:	Yes	No	History of:	Yes	No
Anemia			Gastro Intestinal Problems			Strep Throat		
Asthma			Head Injury (Concussion)			Substance abuse/Alcoholism		
Back Injury/Problem			Headaches (Recurrent)			Surgery		
Blood Transfusion			Hearing Deficit			Appendectomy		
Chickenpox: Date (if known):			Heart Problems			Tonsillectomy		
Contact Lenses			Hepatitis			Other surgery-comment below		
Depression/Anxiety			High Blood Pressure			Tobacco/Marijuana user		
Diabetes			Kidney Problems			**Tb Tuberculosis or positive test**		
Disease/Injury of joints/bones			Learning Disability			Thyroid Disease		
Ear, Nose, Throat Problems			Mononucleosis			Urinary Tract Infection		
Eating Disorders			Seizures			FEMALES ONLY:		
Eye Problems			Sickle Cell Trait/Disease			Birth Control		
Fainting			Skin Condition:			Menstrual Disorder		

Comments on medical/psychiatric history:

_____

_____

List any **daily medications**/conditions for which medications are prescribed:

_____

_____

Any special needs of student: Nature of Disability/Special medical needs:

_____

_____
Student's Signature Date

TO THE STUDENT: This information is confidential & will not be released without your knowledge and written consent. The University will not be liable for any medical history information that is omitted from this form.

SIDE 2 - TO BE FILLED OUT BY THE PHYSICIAN *or* Attach copy of Electronic Medical Record/Provider form

Name: _____ DOB: _____

****Meningitis Vaccine required for all full time students or signed *Meningitis Information Waiver Form* must be submitted.**

VACCINATIONS ✸ = ***Required***	**DATE** Month/Year	**DATE** Month/Year	**DATE** Month/Year	**DATE** Month/Year	**LABS-** recommended **Urinalysis**
***Tdap**	**#1**				Glucose:
***MMR Series or Titers**	**#1.**	**#2.**			Micro:
or *MMR titers Please circle results and note date	1. Measles Titer (Rubeola) Pos Neg **Date:**	2. Mumps Titer Pos Neg **Date:**	3. Rubella Titer Pos Neg **Date**:		**Blood** Hgb. Hct.
***Hepatitis B Series or Titer**	**#1.**	**#2.**	**#3.**	**or** Hepatitis Titer Pos Neg **Date:**	
***Varicella/VAR Series or Titer- If no history of Chickenpox illness**	**#1**	**#2**	**History of Chickenpox Date:**	**or** Varicella Titer: Pos Neg **Date:**	
****Menactra or Menveo (MenACWY) Date must be at or after age 16 years**	**#1**	**#2**	Meningitis B **Not required**; Recommended for high risk individuals	**#1**	**#2** **#3** **Bexero 2 dose series** **Trumenba 2 to 3 dose series**
HPV Vaccine Series (Gardasil)	**#1.**	**#2.**	**#3**		
PPD Mantoux or IGRA TB Test: See TB Screening Form & follow MA State Guidelines for risk:	Month/Year	Neg _____mm	Pos _____mm	**If ppd or IGRA is Positive, Chest X-ray report is required**	
Covid-19 (Mfr)	**#1.**	**#2.**	**FLU yearly**		

- **PHYSICAL EXAMINATION:**

Date of Physical Exam_____ HT: _____ WT: _____ BP: _____ Pulse: _____

SYSTEMS REVIEW: Are there any abnormalities of the following?

	Yes	No		Yes	No
1. Ears, Nose or Throat			7. Genitourinary		
2. Eyes			8. Musculoskeletal		
3. Respiratory			9. Neuropsychiatric		
4. Cardiovascular			10. Metabolic/Endocrine		
5. Gastrointestinal			11. Lymph		
6. Hernia			12. Skin		

Comments: _____

_____

Is the student now under treatment for any medical or emotional condition? Yes ( ) No ( )

Explain: _____

_____

Drug Allergies: Yes_____ No_____ If YES, list drug and reaction: _____

Present Medications: _____

Recommendations for physical activity: Unlimited ( ) Limited ( )
Define activities to be restricted, if applicable: _____

Physician's Signature: _____ **Address**: _____
Date: _____ City: _____
Printed Name: _____ State: _____ Zip: _____
License # & State:_____ Phone: _____

MAIL FORMS TO ADDRESS ON FRONT SIDE: QUESTIONS CALL 413-572-5415