

Whitworth Health History and Immunization Report 2009-10

This form must be submitted prior to your arrival on campus. In order for us to serve you better and to comply with state and federal regulations, we must have your immunization and prior-health history. Return this completed form to the Whitworth Health Center, 300 West Hawthorne Road, Spokane, WA 99251, or fax to 509.777.3763. Each page asks for your name and birthdate; this information is needed as each page may be utilized as a stand-alone document. Thank you for your patience with this process. If you have need of Whitworth Health Center services, we will ask you to fill out a more complete health history on your first visit. If you have specific concerns, Whitworth Support Services may be available to assist in your educational program or with daily life. For more information, please contact the Whitworth Access/Special Needs Office at 509.777.3272 or the Whitworth Health and Counseling Center at 509.777.4450, fax 509.777.3763 or e-mail jmurray@whitworth.edu.

DEMOGRAPHIC INFORMATION

Name: _____
(Last name) (First) (Middle)

Today's date _____ Expected date of entry _____ Social Security no. _____
(Month/Day/Year) (Month/year)

Male _____ Female _____ Date of birth _____ Major _____
(month/day/year)

Permanent home address _____
(Street) (City) (State) (ZIP) (Area Code & Phone No.)

Whitworth address _____ Cell phone _____
(if assigned)

In case of emergency, notify _____
(other than parents) (Name) (Relationship) (Area Code & Phone No.) (Address)

HEALTH INFORMATION:

Allergies to medication _____ If reaction, what kind? _____

Specific illness, disability or disease: _____
(Include childhood illnesses)

Hospitalizations: _____
(Year & reason)

Current medications: _____

Ht. _____ Wt. _____ Most recent physical examination _____

Do you smoke? Yes _____ No _____ Most recent dental examination _____

Do you use alcohol? How often _____ Most recent eye examination _____

Do you have other problems not covered by this questionnaire that are of concern to you? Please explain.

School use only: ID# _____ Meets immunization requirements _____ Yes _____ No _____ Exempt _____
Immunizations Needed: _____

IMMUNIZATION STATUS (Important. Please read carefully.) (Page 2)
To all incoming students: A complete report of your Immunization status is **mandatory** in order for you to register at Whitworth. This policy is in place for the protection of the college community. University students are at greater risk for contracting a variety of diseases. If you do not have recommended protection during an outbreak, you will be asked to leave campus.

The vaccines listed below are recommended by the American Counsel on Immunization Practices, www.cdc.gov/nip/ACIP/default.htm, and the American College Health Association, www.acha.org, for all students.

Name: _____ Birthdate _____ Age _____ Sex _____
(Last) (First) (Middle Initial)

IMMUNIZATION RECORD: This record becomes part of your permanent medical chart and will be updated with any vaccines received at the Whitworth Health Center. *Starred vaccines are available at Whitworth Health Center.

Childhood DPT series of 4. (diphtheria, pertussis, tetanus) and 10-year booster of tetanus and diphtheria

(DPT) Yes _____ No _____ Year completed _____ Last tetanus diphtheria booster _____
(Month/Yr.)

(If more than **10 years**, it is time for another booster. For health sciences students Tdap, one time only, 2 to 5 years after last Td.)
Booster _____ Td* _____ Tdap* _____
(Month/Yr.) (Month/Yr.)

Childhood oral polio series of 3 or 4, depending upon type IPV or OPV

Oral polio, original series Yes _____ No _____ Year completed _____

M.M.R. (measles, mumps and rubella)

(MMR) No. 1 _____ Dose 1 given at 12 months or later ; No. 2 _____ Dose 2 given at least 28 days after dose 1.
(Month/Yr.) (Month/Yr.)

Varicella (chicken pox) (Birth in the U.S. before 1980, a history of chicken pox, or two doses of vaccine meet the requirement.)

Varicella immunization No. 1 _____ No. 2 _____ (series of 2)
(Month/Yr.) (Month/Yr.)

History of disease Yes _____ No _____ Born in U.S. before 1980? _____ Yes _____ No

Hepatitis A & B *

Hepatitis A series #1 _____ #2 _____ (series of 2 if given alone)
(Month/Yr.) (Month/Yr.)

Hepatitis B series #1 _____ #2 _____ #3 _____ (series of 3)
(Month/Yr.) (Month/Yr.) (Month/Yr.)

Hepatitis A & B combined vaccine #1 _____ #2 _____ #3 _____ (series of 3)
(Month/Yr.) (Month/Yr.) (Month/Yr.)

Bacterial meningitis*

Meningococcal Tetravalent Vaccine _____ (See ACIP guidelines)
(Month/Yr.)

Influenza vaccination * Yearly

Not given until after Oct. 15 _____
(Month/Yr.) (Month/Yr.) (Month/Yr.) (Month/Yr.)

Human papillomavirus HPV*

Quadrivalent HPV vaccine. Three-dose series for females age 11-26 years at 0,2, 6 months

No.1 _____ No. 2 _____ No. 3 _____
(Month/Yr.) (Month/Yr.) (Month/Yr.)

Tuberculosis test (PPD) within the last year *

Required if the student is a member of a high-risk group** or is entering the health professions.

Most recent tuberculosis test (PPD) Date _____ Results _____

If you had a positive PPD, chest x-ray results _____ Did you receive INH therapy? Yes _____ No _____

**Go to <http://www.whitworth.edu/Administration/Health&CounselingCenter/Immunization.htm> for high risk criteria.

Pneumonia

Pneumococcal Polysaccharide Vaccine (one dose for members of high risk groups) No. 1 _____
(Month/Yr.)

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

(Student's signature)

(Date)

If you wish to claim exemption to immunization law, please e-mail healthcenter@whitworth.edu and we will e-mail you a copy of the form.

THANK YOU FOR YOUR HELP IN THIS VERY IMPORTANT PERSONAL AND PUBLIC HEALTH ISSUE.

Insurance Information Form

To be used for emergency contact and filing medical claims

Please copy the front and back of the health insurance card/s under which you are covered and attach the copy to this document.

Name _____ Birthdate _____
Local address _____
_____ Local/cell Phone(____) _____
Home address _____
_____ Home phone(____) _____

1. Are you covered by insurance through (please check all that apply) Father Mother Self Whitworth
 Other _____
2. Which of the above is the source of your primary insurance? _____
3. Please provide the following:

Head of household: _____

Date of birth: _____ Home phone: (____) _____

Employer name: _____

Employer phone:(____) _____

Insurance co. name: _____

Insurance co. phone: _____

Insurance co. I.D. no.: _____

Is student insured? (circle one) Yes No

Other parent/spouse: _____

Date of birth: _____ Home phone: (____) _____

Employer name: _____

Employer phone:(____) _____

Insurance co. name: _____

Insurance co. phone: (____) _____

Insurance co. I.D. no.: _____

Is student insured? (circle one) Yes No

If there is a change in coverage or expiration of coverage, I agree to notify Whitworth University of this development and update the insurance information I have on file.

Signature

Date