WOODBURY UNIVERSITY

Welcome to Woodbury University,

To ensure a smooth transition to living on campus, Woodbury University requires that you submit a completed medical record to the Health Services Office before moving into our Residential Communities.

Be sure to complete the attached medical record form including:

- Sections 1 – 7 on page 1
- Health History page 2
- Meningitis On Campus page 4 (Mandatory Vaccine)
- Include a legible copy of your immunization record
- Have a Physician complete page 3 including
  *Recent PPD skin test with results
  *(within 6 months of moving on campus)

Return your competed confidential medical form directly to the Health Services Office. We will accept fax or scanned copies.

Keep a copy in the event the documents are lost in the mail.

Return your competed confidential medical form to the Health Services Office. To ensure this document remains confidential, please send it in its own envelope separate from any other documents you are sending to the University. Your medical documents ONLY should be sent to:

Health Services Office
Woodbury University
7500 Glenoaks Blvd.
Burbank CA 91510-7846

****If your medical form is incomplete it will be returned and you will not be allowed to move into campus housing. It is your responsibility to check with the campus nurse to make sure your documents have arrived at the Health Services Office and are complete. Email the campus nurse at Theresa.somerville@woodbury.edu for confirmation.**

If you have any questions or concerns please contact me. I look forward to seeing you on campus.

Sincerely,

Theresa Somerville, RN, BSN, PHN
Campus Nurse (818) 252-5238 Fax (818) 394-3377

WOODBURY UNIVERSITY HEALTH SERVICES OFFICE

7500 Glenoaks Boulevard, P.O. Box 7846, Burbank, California 91510-7846 Tel: 818.252-5238 Fax: 818.394.3377

USE INK / PLEASE PRINT CLEARLY / STUDENTS MUST COMPLETE ALL 3 PAGES EXCEPT PHYSICAL EXAM PAGE

Last Name First Middle Date of Birth

Birthplace Ethnicity (optional) Gender SS Number

Home Address City State Zip Code Phone Number

Religious Affiliation (optional)_____

PERSONS TO NOTIFY IN EVENT OF EMERGENCY OR ACCIDENT:

Last Name First Middle Relationship

Address City State Telephone

CONSENT:

I hereby give permission for: such diagnostic, therapeutic, preventive, minor operations and emergency procedures as may be deemed necessary and for the Woodbury University Health Services Nurse to speak to my primary health provider regarding my medical information for the purpose of clarification and collaboration.

_____ Date _____

Student (If under Age 18 years Parents or Legal Guardian Must Sign below)

Mother Father

HEALTH INSURANCE INFORMATION:

Name of Health Insurance

Current Primary Health Provider Telephone

ALLERGIES:_____

List all drugs, food, environmental factor, or other agents to which patient is sensitive

IMMUNIZATIONS: MUST BRING COPY OF CURRENT IMMUNIZATIONS TO PHYSICIAN FOR REVIEW

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	Booster
MENINGOCOCCAL (1 dose)	/ /				
TETANUS TOXOID (Td)	/ /	/ /	/ /	/ /	/ /
VARICELLA (1-2 doses)	/ /	/ /			
POLIO(3 doses)	/ /	/ /	/ /		
MEASLES(2 doses)	/ /	/ /			
MUMPS (1 dose)	/ /				
RUBELLA(1 dose)	/ /				
HEPATITIS A (2 doses)	/ /	/ /			
HEPATITIS B (3 dose series or 2 dose)	/ /	/ /	/ /		
other	/ /	/ /	/ /		

HEALTH HISTORY

(To be completed by Student) * Use remarks area below for additional comments.

Check and list year of illness after any of the following you have had. Describe any complications or effects still present under remarks.

- ☐ Chicken Pox
- ☐ German Measles
- ☐ Infectious Mononucleosis
- ☐ Measles
- ☐ Mumps
- ☐ Scarlet Fever
- ☐ Encephalitis
- ☐ Infectious Hepatitis
- ☐ Meningitis
- ☐ Amebiasis
- ☐ Anemia
- ☐ Arthritis
- ☐ Intestinal Parasitic Infection
- ☐ Kidney disease
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Tonsillitis
- ☐ Rheumatic Fever
- ☐ Diabetes
- ☐ Seizure Disorder
- ☐ Heart Disease
- ☐ Tuberculosis
- ☐ *Other

Check the following conditions and/or complaints you have had or subject to at the present time.

- ☐ Head injury
- ☐ Frequent headaches
- ☐ Visual difficulty
- ☐ Difficulty hearing
- ☐ Draining ears
- ☐ Sinus trouble
- ☐ Hay fever
- ☐ Frequent sore throat
- ☐ Any unusual bleeding
- ☐ Menstrual problems
- ☐ Heart murmur
- ☐ Swelling of feet or ankles
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Chronic cough
- ☐ Loss of weight
- ☐ Boils
- ☐ Frequent colds
- ☐ Persistent backache
- ☐ Disease or injury of joints
- ☐ Jaundice
- ☐ Chronic diarrhea
- ☐ Difficulty with urination
- ☐ Sugar or albumen in urine
- ☐ Hernia
- ☐ Abdominal cramps
- ☐ Severe Acne
- ☐ Convulsions
- ☐ Paralysis
- ☐ Fainting spells
- ☐ Dizziness
- ☐ Difficulty sleeping
- ☐ Digestive upsets
- ☐ Skin disease
- ☐ Depression
- ☐ Suicide attempts
- ☐ Phobias
- ☐ Alcohol abuse/dependency
- ☐ Drug abuse/dependency
- ☐ Eating disorder
- ☐ Anxiety/Panic
- ☐ *Other

List surgical operations with dates * _____

List serious accidents or injuries with dates*_____

_____

List medications taken at present (including home remedies)* _____

_____

Do you drink alcohol_____How many times a week/month/year_____

Do you use street or prescription drugs? _____ Type_____ Frequency _____

Do you smoke cigarettes? _____ Number of cigarettes per day _____ Years you have smoked _____

Has your physical activity been limited now or in the past? Why? * _____

Describe your general sleep patterns * _____

Please describe your state of health now * _____

_____

Please describe any physical, mental, or emotional problems not mentioned above _____

_____

FAMILY HISTORY:

Check the following conditions/disorders if any member of your family has had, or is subject to at the present time.

- ☐ Migraine
- ☐ Blood disease
- ☐ Allergy
- ☐ Gout
- ☐ Diabetes
- ☐ *Other
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Epilepsy
- ☐ Tuberculosis
- ☐ Rheumatic Fever
- ☐ Stomach trouble
- ☐ Eating disorder
- ☐ Bipolar disorder
- ☐ Thyroid disease
- ☐ Alcohol/other drug dependence
- ☐ Schizophrenia
- ☐ Suicide
- ☐ Major depression
- ☐ Anxiety/Panic disorder

Remarks _____

_____

_____

PHYSICAL EXAM:

All sections must be completed if not, form will be returned to student.

To the Physician: Please review the history filled in by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student's physical and emotional status, both for the student, and as a basis for his/her continuing medical care. No student who is otherwise qualified will be denied admission because of health conditions.

Height	Weight	Blood Pressure	Pulse

Vision: Uncorrected R 20/_____ L20/_____ Corrected R20/_____ L20/_____

Tuberculin skin test / PPD (must be within 6 months prior to moving on campus) Date Results _____ mm of induration
(Mandatory for On - Campus Residents, Off - Campus Housing and International Students)

Chest x-ray (required within 6 months if PPD skin test is positive) Date Report

Urinalysis Alb. Sugar Micro

Hemoglobin (Women Only) Grams per 100 cc.

	Normal	Abnormal	*Please describe any abnormalities.
Head, EENT			
Neck, nodes			
Cardiovascular			
Respiratory			
Breasts			
Genitourinary			
Gastrointestinal			
Neurologic			
Integumentary			
Endocrine			
Musculo-skeletal			

* Please describe any significant problems _____

* Please describe any current treatment and recommended further examinations or treatment _____

Recommendation for physical activity (check one) ☐ Unlimited ☐ Limited: Please explain _____

Immunization and Allergy Record on page 1 has been verified. ☐ Please Check

Signature of Physician Date

Address Telephone

PHYSCIAN'S NOTES:

_____

_____

_____

_____

_____

Meningitis Vaccine
Know Your Risk
Learn About Vaccination

Certain college students are at increased risk for Meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis.

In fact, freshmen living in dorms are found to have a sixfold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningitis and vaccination.

- What is Meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

- How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

- What are the symptoms? Symptoms of Meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.

- Who is at risk? Certain college students, particularly students who live in dormitories or residence halls, have been found to have an increased risk for Meningococcal meningitis. Other students can also consider vaccination to reduce their risk for the disease.

- Can meningitis be prevented? Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals.

- For more information: To learn more about meningitis and the vaccine, ask your healthcare professional. You can also visit the Centers for Disease Control and Prevention (CDC) websites at: www.cdc.gov/ncidod/dbmd/diseaseinfo, and the American College Health Association, www.acha.org.

WAIVER: I have read the above and the attached information/brochure about the risks meningitis. I have had the opportunity to ask questions to my healthcare provider and have made an informed decision to accept/decline the meningitis vaccine.

____ I request the vaccine be given by Woodbury University Health Services Office
For more information on how to obtain this vaccine and the fee; contact the campus nurse at (818) 252-5238

____ I decline the vaccine because I have already had it (date) _____

____ I have discussed the risks with my healthcare provider and decline the vaccine

Student Signature _____ Date_____

Complete And Return To:

Woodbury University
Health Services Office
7500 Glenoaks Boulevard
Burbank, CA 91510
(818) 252- 5238

Authorization to Consent for Medical Treatment of Minors

I, the undersigned parent / guardian of _____,
(Please print student first & last name)
(Date of Birth)_____ who is below the age of 18, and is or will soon be enrolled at Woodbury University authorize the Registered Nursing Staff of Woodbury University Health Services Office to assess and refer to other appropriate Medical Professionals, to act as my agent(s) to consent to any medical diagnostic procedure, to the administration of any medical or surgical treatment, or to any hospital care needed by the above individual when any or all of the foregoing is deemed advisable by and is to be rendered under the general supervision of any physician/ surgeon licensed in California under the provisions of the Medical Practice Act.

I realize that the above minor must be an enrolled student at Woodbury University to be eligible to receive free services at the Nurse Directed Health Services Office.

I understand that available services are limited to the scope and hours of operation of Woodbury University Health Services Office. I understand that an individual may be referred to off campus medical providers by way of: referrals by the Registered Nurse at Woodbury University Health Services Office, scope or hours of operation of the Student Health Services Office, or at the individual's request.

Signed: _____
(PLEASE PRINT) Name of Parent or Legal Guardian

_____
Signature—Parent or Legal Guardian Date

Street Address: _____

City / State/ Zip: _____

Phone: Home: _____ Work: _____

Cell : _____