UNIVERSITY OF INDIANAPOLIS

Student Health Record

uindy.edu/campus-life/health-wellness-counseling
317-497-6500 / Fax: 317-497-2536

Intended enrollment date: ____________________ , 20 _______ Student Campus ID # **A** ____________________

Instructions:

1. **Get an appointment now with your health care provider, as form must be completed before registration. Please complete in ink. UIndy student athletes must complete this form as well as the form included in the packet from your coach.**
2. This information is strictly for the use of the Health & Wellness Center and will not be released to anyone without written consent.
3. Please complete in English and return to the Health & Wellness Center, 1400 East Hanna Avenue, #108 Health Pavilion, Indianapolis, IN 46227. **Keep a copy for your records.** For questions or to download this form, visit **uindy.edu/campus-life/health-wellness-counseling**

Personal Data Please print.

Citizenship: U.S. ☐ Name of country if not U.S. ____________________ Sex: ☐ M ☐ F Age __________

Full name ____________________ Date of birth ____________________
Last First Middle Maiden

Home address ____________________ City __________ State ________ Zip __________

Home phone ____________________ Student cell phone ____________________

Whom to notify in an emergency? ____________________ Relationship ____________________

Work phone ____________________ Mom cell ____________________ Dad cell ____________________

Family physician ____________________ Phone ____________________

HEALTH CARE FOR MINORS —Complete the following for students who will be under 18 years of age at the beginning of the semester.
I hereby authorize the University of Indianapolis Health & Wellness Center, medical personnel, and other referrals to provide all reasonably necessary medical care including immunizations, treatments for injuries and illnesses advisable for the well-being of my child.

____________________ ____________________
Signature of Parent or Legal Guardian *Date*

Health—*Please answer.*

Allergic to any drugs/medication? ____________________

Any medical conditions? (e.g., asthma, diabetes) ____________________

____

Do you carry an epi pen or such? ____________________ Are you a UIndy athlete? Sport ____________________

Insurance—*Please carry your insurance card.*

Insurance company name ____________________ Phone ____________________

Name of policyholder ____________________ Plan number ____________________

Relationship to student ____________________

Name Last First Middle

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Student Health Record

317-497-6500

Name ____________________ Date of Birth ____________________

I. Immunization Record **Have provider update and list dates for items A–H, then fill out the bottom. If any vaccine has not been given, please go over the risks again, write "no," and initial.** Must be in English. Vaccine records may be found in baby records, high school transcript, previous university, or Health Department.

**If you are in grad OT, PT, or in PTA or Nursing Clinicals, you have extra requirements. Follow your department's instructions. Turn in completed Student Health Record to Health & Wellness Center.*

A. Hepatitis B #1 __________ #2 __________ #3 __________ **Hepatitis A** #1 __________ #2 __________

***Immune IGG titer done (HBsAB) date** __________ **result** __________ ☐ **Attach copy of lab report**

B. Human Papilloma Virus anti-cancer (HPV) males & females: Gardasil

#1 __________ **#2** __________ **#3** __________

C. Meningitis ACWY: *MCV4 ages 11-20, booster at age 16*

Circle brand: Menactra Menveo #1 __________ **#2** __________

Meningitis B: *MenB ages 10-23*

Circle brand: Bexsero Trumenba #1 __________ **#2** __________

D. M.M.R. (Measles, Mumps, Rubella) — 2 doses OR titers required #1 __________ ____ #2 __________

***Immune IGG Titers: Actual lab reports to be attached. (Have indicated if non-immune, get MMR)**

Rubella __________ **Rubeola** __________ **Mumps** __________

E. Polio vaccine—have you had the series? ☐ Yes ☐ No If no, contact your health care provider or the health department.

F. Td (Tetanus–Diphtheria) Tdap (Td & Pertussis): Last booster **within 10 years Td** __________ **Tdap** __________

Must have one Tdap type done no matter how recent last Td has been.

G. Tuberculosis Testing—Must mark appropriate box(es) below and follow instructions.

☐ *OT/PT/PTA students*

☐ Student is *not* international and has no TB symptoms/risks; no testing required.

☐ PPD test (Mantoux) **within the past 3 months.** Date placed ______ Date read __________ Result ______ mm by: ______

☐ Positive PPD—**Chest x-ray required within past year.** Date of chest x-ray ________ Result: ☐ Positive ☐ Negative ***Send report***

☐ Did you take TB medicines to prevent the illness? ☐ No ☐ Yes Meds ____ ________ Date started __________

☐ IGRA (TB lab test) date __________ result __________ ☐ **Attach actual lab report**

H. Varicella (chicken pox) Date of disease __________ ***if not MD office verified must have 2 vaccines or titer***

Vaccine #1 __________ **vaccine #2** __________ **OR Immune IGG titer, attach lab result** __________

Date of last wellness exam __________ Allergies? __________

Are there any physical activity limitations on this student? __________

Daily meds, diagnosis __________

____

☐ Provided education about: alcohol, drugs, sleep, nutrition, no texting while driving, smoking, sexual health, exercise

Provider signature __________ Print name __________ Date __________

Rev. 11/19