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. Please type answers or 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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Name_____ **Date of Birth**_____

I. **Immunization Record** **List the date or dates on which each vaccination dose was administered. If any vaccine has not been given, please write "no".** Must be completed in English. Vaccine records may be found in baby records, high school transcript, previous university, state immunization registry, 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.*

II. **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 & Pertusis): 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 _____

_____

Rev. 8/2025