Note to the Student:
Unless **ALL** required **Immunizations** and **Physical Examination** are submitted by June 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

IMPORTANT
Upload completed health forms on WSU Health Services website.

SIDE 1 - TO BE FILLED OUT BY THE STUDENT

REPORT OF MEDICAL HISTORY

PLEASE PRINT
Complete before going for your physical examination.

Name: Last ____ **First** ____ **M.I.** ____ **Student ID# A...** ____ **WSU 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 (if student under 18)

MEDICAL HISTORY:
Drug Allergies: Yes____ **No**____ If YES, list drug and reaction:______________________________

Other Allergies: Insects, food etc.: ______________________

Please check applicable box below:

History of:	Yes	No	History of:	Yes	No	History of:	Yes	No
Addiction			Gastrointestinal Problems			Strep Throat		
Alcoholism			Head Injury (Concussion)			Substance Use disorder		
Anemia			Headaches (Recurrent)			Surgery		
Asthma			Hearing Deficit			Appendectomy		
Back injury/problem			Heart Problems			Tonsillectomy		
Chickenpox: Date if known			Hepatitis (A, B, C, D, E)			Other surgery-comment below		
Depression/Anxiety			High Blood Pressure			Tobacco/Marijuana user		
Diabetes			Kidney Problems			**Any Non-prescribed drug use**		
Disease/Injury of joints/bones			Learning Disability			Tuberculosis or positive test		
Ear, Nose, Throat Problems			Mononucleosis			Thyroid Disease		
Eating Disorders			Seizures			Cancer: date of dx and type		
Eye Problems			Sickle Cell Trait/Disease			Birth Control		
Fainting			Skin Condition:			Menstrual Disorder		

Have you been hospitalized for mental health concerns? If yes, please write date/place/reason for hospitalization.

____

List any **daily/regular medications/birth control** and conditions for which medications are prescribed:

____

Please explain any YES answers above, note ANY hospitalizations (date/reason), and any special needs below:

____

____
Student's Signature   Date

TO THE STUDENT: This information is confidential and subject to protection under HIPAA. The University will not be liable for any medical history information that is omitted from this form.

SIDE 2 – TO BE FILLED OUT BY MEDICAL PROVIDER. PLEASE ATTACH IMMUNIZATION LIST TO THIS FORM

Name: ______________________________ DOB: ______________

MASSACHUSETTS DPH REQUIRED IMMUNIZATIONS FOR COLLEGE

- **Tdap** 1 dose in past 10 years
- **MMR** 2 doses (given after 1st birthday and at least 28 days apart). Lab evidence of immunity acceptable
- **Varicella** 2 doses (given after 1st birthday and at least 28 days apart) Lab evidence of immunity acceptable
- **Hepatitis B** 3 doses. Lab evidence of immunity acceptable
- **Meningitis ACWY** 1 dose required for all full-time students 21 years of age or younger and must be given after 16th birthday. (Meningitis b vaccine is not required and does not meet this requirement)

WSU HEALTH SERVICES RECOMMENDED IMMUNIZATIONS FOR COLLEGE

- **Meningitis B**
- **Hepatitis A**
- **HPV** (Human Papilloma Virus)
- **Influenza** (annual dose recommended in fall) Look for vaccine clinics on campus!
- **COVID** up to date

- **PHYSICAL EXAMINATION** **Date:** __________ HT: ________ WT: ________ BP: ________ Pulse: ________
- **Tb Risk level:** __________

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 receiving care for any medical or mental health condition? Yes ( ) No ( )

Explain: ____

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

Medications: ____

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

Health Care Provider's Signature: ______________________ **Address:** ______________________
Date: ______________________ City: ______________________

Printed Name: ______________________ State: __________ Zip: __________

License # & State: ______________________ Phone: ______________________

Upload completed form on WSU Health Services website QUESTIONS CALL 413-572-5415