



Counseling, Health, & Wellness Services
 1500 N. Warner St. #1035
 Tacoma, WA 98416-1035

Phone: 253.879.1555
Fax: 253.879.3766
Email: chws@pugetsound.edu

MEDICAL HISTORY AND IMMUNIZATION FORM

Name Last		First		MI	Date form completed
DOB (Mo-Day-Yr)		UPS ID#		Gender Identity	
Home Address Street		City		State	ZIP
Person to be notified in case of emergency Name _____ Relationship _____					Personal Phone () Parent/Guardian Phone ()
The University of Puget Sound requires you to be covered by health insurance while enrolled at the university. By signing below, you are confirming your insurance will cover your medical costs in the state of Washington.					
Name of health insurance company _____ ID# _____ Group# _____					
Medications (including non-prescription medicines, vitamins, and herbs) presently taking. Please be as complete as possible: Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____ Medication/Dose/Frequency: _____					
Medication Allergies: YES NO Please circle those to which you are allergic: Penicillin Sulfa Aspirin Codeine Other Other medication allergies (specify): _____					
Environmental Allergies: YES NO Type/s: _____					
HEALTH CONCERNS—Please check conditions/diseases affecting you or a family member. If NONE apply, check this box <input type="checkbox"/> Please use the following when marking boxes: F=Father M=Mother S=Sibling A=Aunt U=Uncle					
Self	Family	Problem	Self	Problem	Self
		Alcohol or Substance Abuse		ADHD; Type	
		Anxiety		Acne	
		Arthritis		Anemia or Other Blood Problem	
		Bleeding/Blood Clotting Problem		Asthma	
		Cancer; Type/s		Back Problems/Injury	
		Depression		Bladder/Kidney Problems	
		Diabetes; Type		Eating Disorder; Type	
		Epilepsy/Seizures		Eczema	
		Heart Problems		Psoriasis	
		High Blood Pressure		Ear/Nose/Throat Problem	
		High Cholesterol		Eye Problem	
		Thyroid Problem		Headaches; Type	
		Ulcers (Stomach/Duodenal)		Hearing Problems	
		Other:		Hernia	
Please describe checked items:					
Surgery (specify)				Fracture (specify)	
Do you have an illness or condition, not listed above, for which you are now being treated? If yes, specify.					
Do you have any chronic or long-term ongoing condition(s), to include ADHD? (Please have health care provider write a medical summary and attach to this form.)					
List date(s) and reason(s) for any hospitalization, other than surgery.					
Describe present and past symptoms and/or treatment for emotional or psychological problems?					

Name	UPS ID#	DOB (Mo-Day-Yr)
------	---------	-----------------

CONSENT FOR EMERGENCY MEDICAL SERVICES.

MUST BE SIGNED BY ALL STUDENTS. If student is age 17 or younger, must also be signed by parent/guardian:

In case of a medical emergency involving the undersigned student while attending the University of Puget Sound, the undersigned hereby consent(s) to medical personnel designated or authorized by the University of Puget Sound to perform or administer any necessary medical or surgical treatment; provided, however, that if the student is under 18 years of age, the university or physician shall attempt to contact the undersigned parent or guardian for approval before relying on this authorization. In the event the university is required to rely on this consent to authorize necessary medical care and treatment for said student in the case of a medical emergency, the undersigned, individually and jointly, agree to indemnify and hold the university harmless from the costs incurred for said emergency care and treatment, including reasonable attorney's fees and costs incurred in defending and/or instituting a suit to recover said medical expenses.

_____	_____	_____	_____
Student Signature (required)	Date	Parent/Guardian Signature (if student is 17 or younger)	Date

CONSENT FOR NON-EMERGENCY MEDICAL SERVICES.

MUST BE SIGNED BY ALL STUDENTS AGE 17 OR YOUNGER AND PARENT/GUARDIAN:

In case of medical non-emergency care involving the undersigned student while attending the University of Puget Sound, the undersigned acknowledge that if said student is under 18 years of age at the time such treatment is required, and is physically and emotionally capable of consenting, then no additional parental consent is required, consistent with Washington's Mature Minor Doctrine.

_____	_____	_____	_____
Student Signature (required)	Date	Parent/Guardian Signature (if student is 17 or younger)	Date

IMMUNIZATIONS: Please attach copies of immunization records.

The university has adopted a Mandatory Immunization Policy that requires 2 MMR vaccines with the first being on or after their first birthday. Consistent with the policy, you must provide proof of two MMR (measles, mumps, and rubella) immunizations after your first birthday, proof of immunity through titers, or sign a waiver and acknowledgment. We recommend that every student have their own copy of their immunization record (including vaccines such as polio, tetanus, meningococcal, hepatitis, HPV, varicella, and more). If you plan to travel or study abroad, you may also want a record of other immunizations like typhoid, cholera, BCG, yellow fever, plague, hepatitis B, etc.

If you have chosen not to receive immunizations for religious, medical, or personal reasons, you must sign the immunization waiver and acknowledgment below. By signing, you acknowledge that in the event of a measles, mumps, or rubella outbreak on campus, the Pierce County Health Department may require that students who have signed the waiver be excluded from classes or other campus activities, or be asked to leave campus, until proof of immunity is demonstrated. Please note that measles has been a particular problem in the Pacific Northwest in the past several years so there is always potential for exposure to these contagious diseases. In the event of an outbreak, no exceptions to standard University policy for tuition adjustments or refunds will be available.

IMMUNIZATION WAIVER AND ACKNOWLEDGMENT

By signing below, I am acknowledging that I have chosen for religious, medical, or personal reasons not to receive immunizations for measles, mumps, or rubella. I understand that in the event of a measles, mumps, or rubella outbreak on campus, I may be excluded from class or other campus activities, or even asked to leave campus, until I have proof of immunity. No exceptions to standard University policy for tuition adjustments or refunds would be available in those circumstances.

_____	_____
Student Signature	Date
_____	_____
Parent Signature (if student under age 18)	Date