Counseling, Health, & Wellness Services
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Tacoma, WA 98416-1035

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MEDICAL HISTORY AND IMMUNIZATION FORM

Name Last	First	MI	Date form completed
DOB (Mo-Day-Yr)	UPS ID#	Gender Identity	Sex assigned at birth

Permanent Address Street	City	State	ZIP	Phone ( )
Person to be notified in case of emergency **Name** Relationship				Phone ( )

Will you be covered by health insurance while attending Puget Sound? ____Yes ____ No
Will your insurance cover you in Washington State? ____ Yes ____ No
Name of health insurance company _____ ID# _____ Group# _____
*Most Kaiser patients can be seen at Group Health Cooperative

Medications (including non-prescription medicines, vitamins, and herbs) presently taking:

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/Hay Fever:

HEALTH CONCERNS—Please check conditions/diseases affecting you or a family member. If NONE apply, check this box ☐
Please use the following when marking boxes: F=Father M=Mother S=Sibling A/U=Aunt/Uncle

Self	**Family**	**Problem**	**Self**	**Problem**	**Self**	**Problem**
		Alcohol or Substance Abuse		ADHD		Migraine/Frequent/Severe Headaches
		Anxiety		Acne		Pneumonia
		Arthritis		Anemia or Other Blood Problem		Rheumatic Fever
		Bleeding/Blood Clotting Problem		Asthma		Serious Head Injury/Concussion
		Cancer		Back Problems/Injury		Sinusitis
		Depression		Bladder/Kidney Problems		Tobacco Use
		Diabetes (Type I/Type II)		Eating Disorder		Vertigo/Dizziness/Fainting
		Epilepsy/Seizures		Eczema/Psoriasis		Other:
		Heart Problems		Eye/Ear/Nose/Throat Problem		
		High Blood Pressure		Hearing Problems		
		Hyperlipidemia		Hernia		
		Thyroid Problem		Hives		
		Ulcers (Stomach/Duodenal)		Intestinal/Bowel Problems		
		Other:		Menstrual Problems		

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)

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

The undersigned give their consent to medical personnel designated or authorized by the University of Puget Sound, in case of medical emergency involving the undersigned student while attending said university, to perform upon or administer any necessary medical or surgical treatment. 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 addition, the undersigned student must personally consent to said medical procedure if said student is physically and emotionally capable of consenting at the time such treatment is required. In the event the university is required to rely on this consent to authorize necessary medical care and treatment for said student, 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

IMMUNIZATION RECORD: Must be completed and signed by a health care provider, or attach photocopies of medical records (preferred).

VACCINE DOSES	Mo-Day-Yr	Mo-Day-Yr	Mo-Day-Yr	Mo-Day-Yr	Mo-Day-Yr
Oral Polio Vaccine (OPV) 5 doses recommended by age 6	1.	2.	3.	4.	5.
Inactivated Poliovirus Vaccine (IPV)	1.	2.	3.	4.	5.
Diphtheria-Pertussis-Tetanus DTP or DTap (please specify) 5 doses by age 6	1.	2.	3.	4.	5.
Tetanus-Diphtheria DT, Td, or Tdap (please specify) Booster recommended every 10 years	1.	2.	3.	4.	5.
MMR (Measles, Mumps, Rubella) 2 doses on or after first birthday	1.	2.			
Measles (Rubeola) 2 doses after Nov. 1 1968, and on or after first birthday (4-day grace period before first BD). Exempt if born before Jan. 1, 1957.	1.	2.	Provider diagnosed disease or Measles serology: Date: Titer:		
Rubella (German Measles) 1 dose on or after first BD (4-day grace period before first BD)	1.	Provider diagnosed disease or Rubella serology: Date: Titer:			
Mumps 1 dose on or after first birthday (4-day grace period before first BD). Exempt if born before Jan.1 1957.	1.	Provider diagnosed disease or Mumps serology: Date: Titer:			
Hib (H. influenza type b)	1.	2.	3.	4.	
Meningococcal (Meningitis) Group A	1.	2.			
Meningococcal (Meningitis) Group B (Bexsero/Trumenba)	1.	2.	3.		
Influenza (most recent only)	1.				
Hepatitis A	1.	2.			
Hepatitis B	1.	2.	3.		
Human Papilloma Virus (Gardasil) Check one: ☐ HPV4 ☐ HPV9 ☐ HPV12	1.	2.	3.		
PPD tuberculosis skin test (most recent only)	Date placed: Date read:	Result:	Quantiferon Gold TB blood test: T-Spot TB blood test:		
Typhoid Check one: ☐ Oral ☐ Injection	1.	2.	3.	4.	5.
Varicella (Chicken Pox) Date of Vaccination	1.	2.	Provider diagnosed disease or Varicella serology: Date: Titer:		
Yellow Fever	1.				

Signature of Health Care Provider: **Date:**

Circle one: MD DO NP PA RN LPN MA

The University of Puget Sound requires proof of immunity to measles, mumps, and rubella. We recommend that every student have their own copy of this immunization record as well as a record of other immunizations such as typhoid, cholera, BCG, yellow fever, plague, hepatitis B, etc. This information may be needed if you plan to travel or study abroad.

WAIVER

I have had the advantages and disadvantages of immunizations explained to me by a CHWS staff member. I choose for religious, medical, or personal reasons not to receive them. I understand that in the event of a measles, mumps, or rubella outbreak on campus, I may be asked to leave campus until I have proof of immunity.

Student Signature Date

Signature of CHWS staff member Date