

Pacific Lutheran University
International Student Medical History Record
THIS FORM IS REQUIRED FOR ATTENDANCE

Name: _____ Birth date (Mo/Day/Yr) _____
Last First MI

PLU Student ID # _____ Telephone: () _____

Home Address _____
Street Address City State/Province Country Zip/Postal Code

Person to be notified in emergency: _____ Telephone: () _____

Former PLU or EMBASSY CES Student? No Yes, When? _____ Country of citizenship? _____

What term will you enter PLU? Fall J-Term Spring Summer of 20_____

Do you have medical and hospital coverage? No Yes I.D. # _____ Group # _____

Name of insurance carrier: _____ Telephone: () _____

Name of your physician or other health care provider: _____

Address or Location: _____ Telephone: () _____

Health Services Consent and Release

THIS DOCUMENT HAS LEGAL SIGNIFICANCE, PLEASE READ CAREFULLY.

Pacific Lutheran University (PLU) offers limited medical services to all of its full and part-time students. In order for the PLU Health Service personnel to provide health care services for you, the student, it is necessary that you have this medical history record on file PLU Health Services.

PLU will keep your medical records confidential and they will only be used for the provision of health care services. Because of PLU's promise of confidentiality, you, as the student, must inform Residence Hall staff or other university personnel (i.e. physical education instructors or athletic coaches) of any medical condition that you have that could be of concern while you are attending PLU. Furthermore, you are responsible for wearing a Medic Alert bracelet, necklace or similar device to warn health care providers of your diabetes, hemophilia, heart disease, seizure disorder, drug allergies or other significant medical conditions.

As a PLU student, I consent to any necessary medical or surgical treatment in the event of a medical emergency as confirmed by any attending physician, advanced registered nurse practitioner or physician assistant at PLU Health Services. If the student is under 18 years of age, PLU will attempt to contact the undersigned parent or guardian for approval before relying on this consent. In addition, the undersigned student must personally consent to said medical procedure if she/he is physically and emotionally capable of consenting at the time such treatment is required.

In the event PLU is required to rely on this consent authorize necessary medical care and treatment for the student, the undersigned, individually and jointly, agree to indemnify and hold PLU harmless for 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 (Please print and sign your name)

DATE

PARENT OR GUARDIAN SIGNATURE (Required if student is under 18 years of age)

DATE

Return form to: Health Center, Pacific Lutheran University, and Tacoma, Washington ,USA, 98447

Immunization Requirement

You will not be permitted to register without proof of immunization on record at PLU Health Services.

Places to look for official immunization documentation may be your high school, physician's office, parent's official records or military records. If you are unable to locate dates, we will immunize you at the PLU Health Service for a small fee. (253) 535-7337

IMMUNIZATIONS REQUIRED FOR PERSONS BORN AFTER JANUARY 1, 1957. (Persons born before January 1, 1957 are considered immune due to exposure to Measles, Mumps & Rubella and are not required to meet that portion of the immunization requirement)

Rubella (Measles)

Two immunizations with live attenuated virus vaccine *after the student's first birthday and given at least 30 days apart*, physician diagnosed measles or laboratory evidence of rubeola immunity. Persons vaccinated with killed virus or an unknown vaccine prior to 1968 must be revaccinated.

Mumps

Immunization after 1967 and *after the student's first birthday*, a physician documented history of the disease or laboratory evidence of immunity.

Rubella (German Measles)

Immunization with live virus vaccine after 1969 and *after the student's first birthday* or laboratory evidence of rubella immunity.

IMMUNIZATIONS RECOMMENDED FOR ALL STUDENTS:

Hepatitis B, Hepatitis A, Tetanus/Diphtheria booster, meningococcal and chicken pox vaccinations.

REQUIRED IMMUNIZATIONS

MMR # 1 _____/_____/_____ OR Measles # 1 _____/_____/_____ Measles # 2 _____/_____/_____
Month Day Year Month Day Year Month Day Year

MMR # 2 _____/_____/_____ OR Mumps # 1 _____/_____/_____ Rubella # 1 _____/_____/_____
Month Day Year Month Day Year Month Day Year

**** Copies of titer (blood test that show immunity) to measles, mumps, rubella will also be accepted. Please, attach laboratory results. ****

Certification: If you do not attach copies of official records, this must be filled out and signed by a Health Care professional.

Signature of Health Care Professional _____ Date _____

Please answer the following questions. All "yes" answers require further explanation.

Have you had or do you have now?

Allergies

- | | | | |
|--|---|--|--------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Penicillin | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma Onset _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Sulfa | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes Onset _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Antibiotics If yes, what? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizure Disorder Onset _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any other drug or medicine? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anorexia nervosa/Bulimia Onset _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Any food If yes, what? _____ | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other Chronic Illness _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Insect bite If yes, what reaction? _____ | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Have you ever been hospitalized or had any operations? If yes, please explain: _____ | | |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Do you have any physical limitations? If yes, describe any assistance you may need: _____ | | |

Has any person, related by blood, had any of the following?

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes If yes, who? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure If yes, who? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke If yes, who? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer If yes, who and what type? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart attack before age 55 If yes, who? _____ |