

WOODBURY UNIVERSITY

Welcome to Woodbury University,

To ensure a smooth transition to living on campus, Woodbury University requires that you submit a completed medical record to the Health Services Office before moving into our Residential Communities.

Be sure to complete the attached medical record form including:

- Sections 1 - 7 on page 1
- Health History page 2
- Meningitis On Campus page 4 (Mandatory Vaccine)
- Include a legible copy of your immunization record
- Have a Physician complete page 3 including
 - *Recent PPD skin test with results
 - *(within 6 months of moving on campus)

Return your completed confidential medical form directly to the Health Services Office. We will accept fax or scanned copies.

Keep a copy in the event the documents are lost in the mail.

Return your completed confidential medical form to the Health Services Office. To ensure this document remains confidential, please send it in its own envelope separate from any other documents you are sending to the University. Your medical documents ONLY should be sent to:

Health Services Office
Woodbury University
7500 Glenoaks Blvd.
Burbank CA 91510-7846

****If your medical form is incomplete it will be returned and you will not be allowed to move into campus housing. It is your responsibility to check with the campus nurse to make sure your documents have arrived at the Health Services Office and are complete. Email the campus nurse at Theresa.somerville@woodbury.edu for confirmation.**

If you have any questions or concerns please contact me. I look forward to seeing you on campus.

Sincerely,

Theresa Somerville, RN, BSN, PHN
Campus Nurse (818) 252-5238 Fax (818) 394-3377

1.818.767.0888 check us out online @woodbury.edu
7500 Glenoaks Boulevard, Burbank, CA 91510-7846

WOODBURY UNIVERSITY HEALTH SERVICES OFFICE

7500 Glenoaks Boulevard, P.O. Box 7846, Burbank, California 91510-7846 Tel: 818.252-5238 Fax: 818.394.3377

USE INK / PLEASE PRINT CLEARLY / STUDENTS MUST COMPLETE ALL 3 PAGES EXCEPT PHYSICAL EXAM PAGE

Last Name _____ First _____ Middle _____ Date of Birth _____

Birthplace _____ Ethnicity (optional) _____ Gender _____ SS Number _____

Home Address _____ City _____ State _____ Zip Code _____ Phone Number _____

Religious Affiliation (optional) _____

PERSONS TO NOTIFY IN EVENT OF EMERGENCY OR ACCIDENT:

Last Name _____ First _____ Middle _____ Relationship _____

Address _____ City _____ State _____ Telephone _____

CONSENT:

I hereby give permission for: such diagnostic, therapeutic, preventive, minor operations and emergency procedures as may be deemed necessary and for the Woodbury University Health Services Nurse to speak to my primary health provider regarding my medical information for the purpose of clarification and collaboration.

Student _____ (If under Age 18 years Parents or Legal Guardian Must Sign below) Date _____

Mother _____ Father _____

HEALTH INSURANCE INFORMATION:

Name of Health Insurance _____

Current Primary Health Provider _____ Telephone _____

ALLERGIES:

List all drugs, food, environmental factor, or other agents to which patient is sensitive

IMMUNIZATIONS: MUST BRING COPY OF CURRENT IMMUNIZATIONS TO PHYSICIAN FOR REVIEW

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	Booster
MENINGOCOCCAL (1 dose)	/ /				
TETANUS TOXOID (Td)	/ /	/ /	/ /	/ /	/ /
VARICELLA (1-2 doses)	/ /	/ /			
POLIO(3 doses)	/ /	/ /	/ /		
MEASLES(2 doses)	/ /	/ /			
MUMPS (1 dose)	/ /				
RUBELLA(1 dose)	/ /				
HEPATITIS A (2 doses)	/ /	/ /			
HEPATITIS B (3 dose series or 2 dose)	/ /	/ /	/ /		
other	/ /	/ /	/ /		

HEALTH HISTORY

(To be completed by Student)

* Use remarks area below for additional comments.

Check and list year of illness after any of the following you have had. Describe any complications or effects still present under remarks.

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Intestinal Parasitic Infection | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Infectious Hepatitis | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Amebiasis | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Arthritis | | <input type="checkbox"/> *Other |

Check the following conditions and/or complaints you have had or subject to at the present time.

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Swelling of feet or ankles | <input type="checkbox"/> Difficulty with urination | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sugar or albumen in urine | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Visual difficulty | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hernia | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Abdominal cramps | <input type="checkbox"/> Phobias |
| <input type="checkbox"/> Draining ears | <input type="checkbox"/> Loss of weight | <input type="checkbox"/> Severe Acne | <input type="checkbox"/> Alcohol abuse/dependency |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Boils | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Drug abuse/dependency |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Persistent backache | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Anxiety/Panic |
| <input type="checkbox"/> Any unusual bleeding | <input type="checkbox"/> Disease or injury of joints | <input type="checkbox"/> Dizziness | <input type="checkbox"/> *Other |
| <input type="checkbox"/> Menstrual problems | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Difficulty sleeping | |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Digestive upsets | |

List surgical operations with dates * _____

List serious accidents or injuries with dates* _____

List medications taken at present (including home remedies)* _____

Do you drink alcohol _____ How many times a week/month/year _____

Do you use street or prescription drugs? _____ Type _____ Frequency _____

Do you smoke cigarettes? _____ Number of cigarettes per day _____ Years you have smoked _____

Has your physical activity been limited now or in the past? Why? * _____

Describe your general sleep patterns * _____

Please describe your state of health now * _____

Please describe any physical, mental, or emotional problems not mentioned above _____

FAMILY HISTORY:

Check the following conditions/disorders if any member of your family has had, or is subject to at the present time.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach trouble | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Major depression |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anxiety/Panic disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Alcohol/other drug dependence | |
| <input type="checkbox"/> *Other | <input type="checkbox"/> Rheumatic Fever | | |

Remarks _____

PHYSICAL EXAM:

All sections must be completed if not, form will be returned to student.

To the Physician: Please review the history filled in by the student and add or complete anything of significance. After a complete physical examination, we would appreciate your evaluation of the student's physical and emotional status, both for the student, and as a basis for his/her continuing medical care. No student who is otherwise qualified will be denied admission because of health conditions.

 Height Weight Blood Pressure Pulse

 R 20/ L20/ R20/ L20/
 Vision: Uncorrected Corrected

 Tuberculin skin test / PPD (must be within 6 months prior to moving on campus) Date Results
 (Mandatory for On - Campus Residents, Off - Campus Housing and International Students) mm of induration

 Chest x-ray (required within 6 months if PPD skin test is positive) Date Report

 Urinalysis Alb. Sugar Micro

 Hemoglobin (Women Only) Grams per 100 cc.

	Normal	Abnormal	*Please describe any abnormalities.
Head, EENT			
Neck, nodes			
Cardiovascular			
Respiratory			
Breasts			
Genitourinary			
Gastrointestinal			
Neurologic			
Integumentary			
Endocrine			
Musculo-skeletal			

* Please describe any significant problems _____

* Please describe any current treatment and recommended further examinations or treatment _____

Recommendation for physical activity (check one) Unlimited Limited: Please explain _____

Immunization and Allergy Record on page 1 has been verified. Please Check

 Signature of Physician Date

 Address Telephone

PHYSICIAN'S NOTES:

Meningitis Vaccine
Know Your Risk
Learn About Vaccination

Certain college students are at increased risk for Meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis.

In fact, freshmen living in dorms are found to have a sixfold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningitis and vaccination.

- What is Meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.
- How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
- What are the symptoms? Symptoms of Meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
- Who is at risk? Certain college students, particularly students who live in dormitories or residence halls, have been found to have an increased risk for Meningococcal meningitis. Other students can also consider vaccination to reduce their risk for the disease.
- Can meningitis be prevented? Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals.
- For more information: To learn more about meningitis and the vaccine, ask your healthcare professional. You can also visit the Centers for Disease Control and Prevention (CDC) websites at: www.cdc.gov/ncidod/dbmd/diseaseinfo, and the American College Health Association, www.acha.org.

WAIVER: I have read the above and the attached information/brochure about the risks meningitis. I have had the opportunity to ask questions to my healthcare provider and have made an informed decision to accept/decline the meningitis vaccine.

_____ I request the vaccine be given by Woodbury University Health Services Office
For more information on how to obtain this vaccine and the fee; contact the campus nurse at (818) 252-5238

_____ I decline the vaccine because I have already had it (date) _____

_____ I have discussed the risks with my healthcare provider and decline the vaccine

Student Signature _____ **Date** _____

**Complete And Return To:
Woodbury University
Health Services Office
7500 Glenoaks Boulevard
Burbank, CA 91510
(818) 252- 5238**

Authorization to Consent for Medical Treatment of Minors

I, the undersigned parent / guardian of _____,
(Please print student first & last name)

(Date of Birth)_____ who is below the age of 18, and is or will soon be enrolled at Woodbury University authorize the Registered Nursing Staff of Woodbury University Health Services Office to assess and refer to other appropriate Medical Professionals, to act as my agent(s) to consent to any medical diagnostic procedure, to the administration of any medical or surgical treatment, or to any hospital care needed by the above individual when any or all of the foregoing is deemed advisable by and is to be rendered under the general supervision of any physician/ surgeon licensed in California under the provisions of the Medical Practice Act.

I realize that the above minor must be an enrolled student at Woodbury University to be eligible to receive free services at the Nurse Directed Health Services Office.

I understand that available services are limited to the scope and hours of operation of Woodbury University Health Services Office. I understand that an individual may be referred to off campus medical providers by way of: referrals by the Registered Nurse at Woodbury University Health Services Office, scope or hours of operation of the Student Health Services Office, or at the individual's request.

Signed: _____
(PLEASE PRINT) Name of Parent or Legal Guardian

Signature—Parent or Legal Guardian

Date

Street Address: _____

City / State/ Zip: _____

Phone: Home: _____ Work: _____

Cell : _____