# LA SIERRA UNIVERSITY

**STUDENT WELLNESS SERVICES STUDENT HEALTH RECORD**

**PERSONAL INFORMATION:**

Name: _____Sex:_____Age:_____DOB: _____
Last First Middle

Home Address: _____Telephone: _____
Street City State Zip Code

Local Address: _____ Cell phone: _____
Street City State Zip Code

Private Physician's Name: _____ Telephone: _____

Address: _____
Street City State Zip Code

**Person to be Notified in case of Emergency**: _____ Relationship: _____

Address: _____ Telephone: _____
Street City State Zip Code

Medical Insurance (Company's Name & Policy #): _____

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**PERMISSION FOR TREATMENT (For Students under the Age of 18):**

We, the undersigned, Parent/Legal Guardian of _____ a minor, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the instructions of La Sierra University Student Health Services' health care providers, whether such diagnosis or treatment is rendered at Student Health Services, Physician's Office, or at a Hospital licensed by the State of California. This consent is given in advance to allow the staff of Student Health Services to exercise their best judgment so as to provide prompt medical service to said minor.

Date: _____ Signature: _____ Printed Name: _____
(Parent/ Legal Guardian)

Date: _____ Signature: _____ Printed Name: _____
(Witness)

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**MAIL** or **FAX** the completed form (pages 1 to 4) to:
LA SIERRA UNIVERSITY
STUDENT WELLNESS SERVICES
4500 Riverwalk Parkway
Riverside, CA 92515 **Telephone: (951) 785-2200** **FAX: (951) 785-2263**

**PATIENT'S NAME:** _____ **DOB:** _____
Last First Middle

**PERSONAL MEDICAL HISTORY:**
What medical conditions have required care in the past five years? _____
Have you been involved in personal counseling in the past five years? Yes _____ No _____
What medications are you taking regularly? _____

**Drug Allergy:** _____
Hospitalizations (Date & Reason) _____
What operations have you had? (Provide year) _____
Have you had any injuries? (provide year) _____

**Circle** any of the following illnesses you have had and **explain** in further detail:

| | | | | | |
|---|---|---|---|---|---|
| Acne | Anemia | Asthma | Bone/Joint Pain | Bronchitis | Chickenpox |
| Diabetes | Ear Infection | Hay Fever | Hepatitis | Hernia | High Blood Pressure |
| Hives | Infectious Mono | Kidney/Bladder Disease | | Malaria | Measles |
| Pneumonia | Seizures | Sexually Transmitted Infection | | Thyroid Disease | Tonsillitis |
| Ulcers | Other _____ | | | | |

Explain further: _____
_____

**FAMILY MEDICAL HISTORY:**
Has any member of your family (including grandparents) had the following? (**Circle**)

| | | | | |
|---|---|---|---|---|
| Allergies | Asthma | Cancer | Diabetes | Heart Disease |
| High Blood Pressure | Seizures | Tuberculosis | Other_____ | |

**REVIEW OF SYSTEMS:**

**PATIENT'S NAME:** _____ **DOB:** _____
Last First Middle

## IMMUNIZATIONS and PROOF OF IMMUNITY

INCOMING STUDENTS MUST FILE PROOF OF IMMUNIZATIONS PRIOR TO THE START OF THEIR FIRST QUARTER.

Instructions:
1. Have this form completed legibly in ENGLISH by a licensed medical professional unrelated to the student.
2. If the required immunizations have been documented on an official immunization record, a copy of the immunization record may be sent in lieu of a medical professional completing this form. Foreign records MUST be translated into ENGLISH

**A. Measles-Mumps-Rubella (MMR) vaccine:** Two (2) doses **required** for student born after 1956
Dose #1 given at 12 months of age or later _____ Dose #2 given at least 1 month after dose #1 after 1980 _____

**B. Hepatitis B vaccine** (optional but recommended for students 19 years of age and older)
**Hep B vaccine required if the student has not yet turned 19 on the first day of the entering quarter.**

☐ Hepatitis B vaccine 3-dose program initiated or completed
Vaccíne Dates: Dose #1 _____ Dose #2 _____ Dose #3 _____

☐ Student has known immunity against the Hepatitis B virus by prior infection or by known immune antibody titer (Copy of lab report required)
Hepatitis B surface antibody titer _____ Date _____

☐ Student is a known chronic carrier of Hepatitis B therefore vaccine is not indicated

**C. Tetanus-Diphtheria-Pertussis (Tdap) vaccine booster**
Received within the last ten (10) years Date _____

**D. Meningococcal Vaccine (recommended but not required) One (1) dose**
This vaccine is optional for admission to La Sierra University, but is strongly recommended for students who will be residing on campus.

Date vaccine given: _____

### MEDICAL PROFESSIONAL CERTIFICATION REQUIRED

Name _____ Professional Title _____ License No. _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____

Signature indicates that all information on this page is true and accurate, to the best knowledge of the responsible medical professional

_____ _____
Signature Date

**PATIENT'S NAME:** _____ **DOB:** _____
Last First Middle

Date:

Comments on Medical History: _____
_____
_____
_____

Ht: _____Wt: _____ B.P.: _____ T: _____ P : _____ R : _____
Vision: R _____ L _____ (Corrected): R _____ L _____
LMP if Female: _____
HEENT: _____
Neck: _____
Lungs: _____
Heart: _____
Abdomen: _____
Extremities: _____
Back: _____
Musculoskeletal: _____
Neurological: _____
Genitalia (Optional): _____
_____
Assessment: _____
_____

Plan: Circle if Ordering

1. TB Skin Test: Given on _____ Read on _____ Induration _____ mm ☐ Positive ☐ Negative
   If positive, chest x-ray required.
2. Chest X-ray- include copy of report
3. Hep B # _____
4. MMR # _____
5. Tdap
6. *U/A-if needed
7. *Hgb-if needed

*INCLUDE RESULT(S) IF DONE.

Signature: _____ Name (Printed): _____
(Physician) (Physician)

Address: _____ Date: _____
Street City State Zip Code

Telephone: _____

**LA SIERRA UNIVERSITY, RIVERSIDE CA**
**STUDENT WELLNESS SERVICES**
**Phone: (951) 785-2200 Fax: (951) 785-2263**
**PHYSICAL PROGRESS NOTE**

LAST NAME:
FIRST NAME:
ID #:
BIRTHDAY: