Wabash Student Health Center

Information and Instructions for Completing the Student Health Record

Dear Incoming Wabash Student:

Welcome to Wabash College! In order to make your experience at Wabash a healthy one, we ***REQUIRE*** every student to have a completed Student Health Record (SHR) on file at the Student Health Center. You must COMPLETE the form and return it to the Wabash College Student Health Center **by the date indicated in your introductory letter** which will allow us time to review and **contact you via e-mail** if you have failed to provided required information. Please note, you **WILL NOT BE ALLOWED TO REGISTER FOR FALL CLASSES** IF YOUR COMPLETED health record is not received by the registration date.

The Wabash College nurse checks all SHRs for compliance, particularly the immunization dates. She also reviews medications, pertinent allergies, chronic diseases and other health issues so that we may provide the appropriate health services to our students. Please note that we do not require students to have a physical exam prior to coming to Wabash.

Please print off the Student Health Record found below, complete it, and either fax it to our secure fax line (765-361-6269), email a scanned copy to <lambc@wabash.edu> or mail it (preferred) to the following address:

Wabash College Student Health Center
Attn: Nurse Carol Lamb
P.O. Box 352
Crawfordsville, IN 47933

Health Insurance Information
This information must be completed by going to www.swol123.net **in addition to completing the SHR**

Immunizations
Typically, SHRs are judged incomplete because the immunization section was not completed correctly. Please do not simply send a copy of your "Childhood Immunization Record." We need you to have this information *transferred* onto our SHR form and have it signed by a health professional. If you have declined to be vaccinated, you must read, complete and sign the "Request for Exemption from Vaccination Requirement" form found on the student health center web page www.wabash.edu/studentlife/health and mail to the address above.

Holds – For Those Students with Incomplete or no SHR
We do not want to place a hold on a student's registration so we take the following steps prior to placing the hold:

- Audit all SHRs for completeness.
- Students may receive a "waive" if in the middle of an immunization series (i.e. Hepatitis B).
- Send e-mails to the student via Wabash student e-mail regarding the possibility of a hold due to missing SHR information.

International Students
We require verification of the placement and reading of a PPD (Mantoux) test for exposure to tuberculosis within a year of the start date of school. The result must be **dated** and the results read **in millimeters of induration**. If your Mantoux test was positive, you need to have had a chest X-ray performed within the last year and attach a copy of the report to your SHR. If you have received bCG vaccine and your PPD was positive, we require you to have an Interferon gamma assay (QuanitFERON) test to confirm TB infection.

Attestation
Remember to **sign and date the SHR** at the bottom of page 3.

Intercollegiate Athletic Participation
All intercollegiate athletes will be required to have a physical examination performed by the college medical staff *before* participating in their first year of practice or competition. Your coach or the college trainer will inform you of the date of the physical for your sport.

Additional Health Center Information

If you take prescription medication, have your personal physician write you a prescription with enough refills to get you through the school year. If you are taking medications for ADD/ADHD such as Ritalin, Concerta, Adderall, Vyvanse, Focalin etc., also ask your personal physician to write your prescriptions. We will not refill controlled substances without health records and a signed authorization from your treating physician. ***Varsity athletes*** who have been diagnosed with ADD/ADHD and who take stimulant medication will need to have their physician complete the NCAA form found at https://goo.gl/uZCSDw and forward it to the Wabash athletic trainers. Please note the documentation that is required from your treating physician. If you wear contacts, we strongly recommend you have a backup pair of glasses in case you develop an eye infection, which may not allow the use of contact lenses for a period of time.

If you have a history of mental illness or are taking psychiatric medications we request that you contact the college nurse at 765-361-6265 or email her at <lambc@wabash.edu> well in advance of coming to school in the fall. This will allow us to determine possible at-risk students and what type of local psychiatric care you may require. The college physicians do treat mild cases of depression and there is a counseling service available on campus. Be advised that the curriculum and extra-curricular activities at Wabash can be extremely demanding and can be a strain on young men with a history of mental illness.

If you have private health insurance, it may have a limited network of doctors or other restrictions and may not provide coverage in Crawfordsville. It is also imperative that if you are covered by your family health insurance that you have a copy your insurance card with you at school (please attach a photocopy of the front and back of the card to your Student Health Record). Our school nurse also handles all of the student health insurance issues in addition to her nursing duties.

If you are age 18 or older, information regarding the care you receive while at Wabash is protected by federal law. Parents will be informed only when authorized by the student or in emergency situations. Parents may also be informed if a student has a health problem where he could present a danger to himself, other students or the college staff.

If you have any questions regarding the Student Health Center, feel free to stop in, call, or email us. Have a safe and enjoyable summer and we look forward to seeing you in the fall.

Sincerely,

Scott K. Douglas, M.D. ’84
John R. Roberts, M.D. ’83
Carol Lamb, R.N.

Wabash College
Student Health Center
P.O. Box 352
Crawfordsville, IN 47933
Voice 765-361-6265 • Fax 765-361-6269

Student Health Record

Intended date of enrollment: _____

Instructions to Student

1. Answer all questions using black ink. This information is for the use of the medical staff of the Student Health Center and the Wabash Athletic Department. It may be released for purposes of medical treatment, payment or health care operations of the Wabash Student Health Center or Athletic Department.
2. Present this form to your physician or his/her nurse and request that he/she review the information and verify your immunization status.
3. This form is **mandatory** for all students and must be returned to Wabash College **by the date indicated in your introductory letter**. Please note that you **will not be allowed to register for classes** if we do not have an up-to-date immunization record. Immunizations may only be waived for religious reasons by providing us a letter from the leader of your organization on its letterhead.

Personal Data

Full Name: _____ Date of birth: _____
Last First Middle

Citizenship: U.S. ☐ Other: ☐ _____ Marital status (circle): M S W D

Social Security Number: _____ Cell Phone Number: _____

Home Address: _____ City _____ State _____ Zip _____

Emergency Contact: _____ Relationship _____

Address: _____ Phone: ( ) _____ Cell: ( )_____

Personal physician: _____ Telephone: ( ) _____ Fax: ( ) _____

Address: _____

To be signed by a parent or legal guardian if the student is under 18 years of age.

I hereby authorize the Wabash College physicians, nurse, and athletic trainer to examine and/or treat for minor injury or illness and when considered necessary, to make a referral to an appropriate medical facility or another treating physician. I also consent to emergency treatment or procedures by a licensed physician if deemed necessary.

Signature: _____ Relationship (if guardian): _____

Telephone if guardian: ( ) _____

Insurance Information

Card Holder's date of birth: _____ and Social Security No.: _____

(Attach a copy of the front and back of Insurance Card)

Please Complete the Separate Health Insurance Information at www.swol123.net

Student Name: _____ Date of Birth: _____

Immunization Record

REQUIRED

A. Diptheria-Pertussis-Tetanus
Childhood series completed_____ (mo/year)
***BOOSTER in last 10 years*_____ (mo/year)**

B. MMR (Measles, Mumps, Rubella)
At 12 mos or before 5 yrs: _____ (mo/year)
Booster at age 5 or later: _____ (mo/year)
If received MMR, skip C,D,E

C. Rubeola
Confirmed Disease: _____ (mo/year)
Live vaccine: _____ (mo/year)

D. Rubella
Confirmed Disease: _____ (mo/year)
Vaccine: _____ (mo/year)
Immune titer: _____ (mo/year)

E. Mumps
Confirmed Disease: _____ (mo/year)
Vaccine: _____ (mo/year)

F. Polio
Type of vaccine ☐ oral ☐ inactivated
Completed series: _____ (mo/year)
Booster _____ (mo/year)

G. Varicella (chickenpox)
Confirmed disease or titer:_____ (mo/year)
Dates of vaccines (2): _____ _____

Required for foreign students or students exposed to tuberculosis (TB)

H. Tuberculosis
PPD (mantoux) test within past year (even if received bCG vaccine)
Result: ____ mm induration Date: _____
Chest X-ray for positive: Date: _____
Results: _____
bCG vaccine administered: _____ (mo/year)
QuantiFERON if positive PPD _____

OPTIONAL VACCINES (*Recommended)

I. *Hepatitis B series: _____ _____ _____
J. *Meningococcal: _____ _____
K. *Hepatitis A: _____ _____
L. Yellow Fever: _____
M. Typhoid: _____
N. Other: _____

I certify that the above immunization information is correct to the best of my knowledge (**physician or licensed nurse)**

_____ _____
Health Professional Signature Date

Personal Medical History

Medications you are taking (include vitamins, herbs, etc.): _____
_____

Medication allergies: _____
_____

Surgeries: _____

Past History (check if you have had any of the following in the past):

☐ Mononucleosis
☐ Rheumatic Fever
☐ Diabetes
☐ Eye problems
☐ Ear/nose/throat disease
☐ Endocrine/thyroid disease
☐ Emotional problems
☐ Head injury
☐ Seizures
☐ Chest disease/asthma
☐ Heart disease
☐ Hypertension
☐ Anemia
☐ Gastrointestinal disease
☐ Jaundice
☐ Kidney/bladder disease
☐ Sexually transmitted disease
☐ Back/joint problems
☐ Cancer/tumor/cyst
☐ Physical handicap
☐ Skin disease
☐ Serious illness/accident
☐ Eating disorder
☐ Substance abuse
☐ Smoking
☐ Alcohol abuse

Space for notes on past history

Student Name: _____ Date of Birth: _____

Family History

	Age	State of health	Age at death	Cause of death
Father				
Mother				
Brothers/				
Sisters				

Have any of your relatives ever had any of the following?

	Yes	Relationship
Tuberculosis		
Diabetes		
Hypertension		
Heart disease		
Arthritis		
Hay fever		
Cancer		

AUTHORIZATION

I authorize and request the Wabash College Student Health Center to administer outpatient medical and surgical services and immunizations as indicated and to perform emergency procedures as necessary or to refer to other licensed medical personnel, when indicated, including admission to hospitals if necessary. I hereby state that I am capable of safely participating in vigorous physical activity unless otherwise indicated on this form. Medical information withheld, incomplete or incorrect relieves Wabash College and its agents from all medical or legal liability and may disqualify you from participation in athletics or club sports. The information given on this form is correct to the best of my knowledge. I give permission for this information to be shared, when necessary, for my treatment, payment for services or for health care operations of the Wabash College Student Health Center and the Wabash College Athletic Department.

Record any additional details/information below:

_____ _____
Signature if student over 18 Date

_____ _____ _____
Parent/guardian signature if under 18 Relationship Date

Additional Health Center information can be found at www.wabash.edu/studentlife/health