DAKOTA WESLEYAN UNIVERSITY

Student Health Form

The DWU STUDENT HEALTH FORM including IMMUNIZATIONS IS REQUIRED FOR ALL STUDENTS (enrolled in 12 or more credit hours) ENTERING AS A FRESHMAN, TRANSFER OR READMIT. Please fill out the front page and top of the back page BEFORE going to your physician. Please PRINT all information.

The DWU STUDENT HEALTH FORM must be received and immunization status approved before you are permitted to attend class.

Full Name _____ (Last / First / Middle Initial) ❑ Male ❑ Female (Check One) Date of Birth _____ / _____ / _____ (Month / Day / Year)

Home Address _____ (Street Address / City / State / Zip)

Home Phone Number (_____) _____ Student's Cell Phone Number (_____) _____ Student's Email Address _____

Emergency Contact No. 1 _____ (Full Name / Relationship / Phone No. 1 / Phone No. 2)

Emergency Contact No. 2 _____ (Full Name / Relationship / Phone No. 1 / Phone No. 2)

Family Physician _____ (Name / Street Address / City, State, Zip) (_____) _____ (Phone Number)

Date of Entry to DWU _____ / _____ (Month / Year) Entering as: ❑ Freshman ❑ Transfer ❑ Readmit Residence: ❑ On Campus ❑ Commuter Are you a veteran? ❑ Yes ❑ No

FAMILY HISTORY

	Age	State of Health	Occupation	Age, Cause of Death
Father				
Mother				
Brother				
Brother				
Sister				
Sister				

What any relative currently has or has had (list relationship):

Alcoholism _____
Asthma, Hay Fever _____
Cancer _____
Diabetes _____
Epilepsy, Convulsions _____
Heart Disease _____
High Blood Pressure _____
Kidney Disease _____
Tuberculosis _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking:

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please identify specific allergy below.

❑ Medicines ❑ Pollens ❑ Food ❑ Stinging Insects

PERSONAL HISTORY (Please answer all questions.)

Have you had or are you concerned about?

	Yes	No		Yes	No		Yes	No
Alcohol/Drug Use			Heart Murmur			Scarlet Fever		
Anxiety/Panic Attacks			Heart Palpitation			Severe Headaches/Migraines		
Arthritis			Heat Illness			Sexually Transmitted Disease/HIV		
Asthma, Hay Fever			Hernia			Shortness of Breath		
Back Problem			High/Low Blood Pressure			Sickle Cell Anemia		
Birth Defect			History of Chicken Pox			Sinusitis		
Bleeding Disorder			Indigestion			Stomach/Intestinal Trouble		
Bone and Joint Injury			Jaundice			Suicidal Thoughts		
Cancer/Cyst			Latex Allergy			Thyroid Trouble		
Chemical Dependency			Malaria			Trouble Sleeping		
Chest Pain/Pressure			Measles			Urinary Tract Problems		
Chronic Cough			Measles (German)			Weakness, Paralysis		
Depression			Mental Illness			Worry, Nervousness		
Diabetes			Mononucleosis			Female Students:		
Dizziness/Fainting			MRSA/Skin Disorders			Excessive Flow		
Ear/Nose/Throat Trouble			Mumps			Irregular Periods		
Eating Disorder			Pneumonia/Bronchitis			Pregnancy		
Epilepsy/Seizure Disorder			Polio			Severe Cramps		
Eye Trouble			Recent Weight Gain/Loss					
Gallbladder Trouble			Recurrent Diarrhea					
Gum/Tooth Trouble			Recurrent Tonsillitis/Strep Throat					
Head Injury/Concussion			Rheumatic Fever					

If "yes," explain the condition and list anything that is NOT covered above that you feel DWU campus nurse should be aware of. Please describe and use the back of the form if needed.

_____

_____

DAKOTA WESLEYAN UNIVERSITY

Student Health Form

NAME: _____

	Yes	No	Please explain any "Yes" responses.
Have you had any illness, injury or surgery which required hospitalization?	❑	❑	_____
Have you consulted or been treated by a clinic, physician or other practitioners within the past five years?	❑	❑	_____
If so, have any of your activities been restricted in the past five years?	❑	❑	_____
Have you been rejected or discharged from military service because of physical, emotional or other reasons?	❑	❑	_____
Do you suffer from post traumatic stress disorder?	❑	❑	_____
Do you have documented learning, psychological or physical disabilities?	❑	❑	_____
Have you ever had psychiatric or psychological counseling?	❑	❑	_____
Are you participating in intercollegiate sports?	❑	❑	List sport(s) _____
Do you require any special diet? (Examples: diabetic diet, gluten free)	❑	❑	_____

If "yes," contact the DWU Aramark Director at 605-995-2810 or email DWUAramark@dwu.edu.

Tuberculosis (TB) Screening

If you answer **"YES"** to any of the four questions below, Dakota Wesleyan University requires that a healthcare provider complete a tuberculosis risk assessment within six months before the start of classes. All costs associated with the assessment shall be the responsibility of the student.

1. Have you ever been vaccinated with Bacillus Calmette Guerin? ❑ Yes ❑ No
2. Are you from or have you ever lived for two months or more in Asia, Africa, Central or South America, or Eastern Europe? ❑ Yes ❑ No
3. Have you ever had close contact with anyone who was sick with TB? ❑ Yes ❑ No
4. Have you ever had a **positive** TB skin test? ❑ Yes ❑ No *If "**NO**," disregard chest X-ray question.*

   Chest X-ray Result: ❑ Normal ❑ Abnormal Date of Chest X-ray: _____ / _____ / _____ (Attach a copy of X-ray report.)

I have truthfully answered all of the questions listed on this **DWU STUDENT HEALTH FORM** and understand that withholding any history before injury or illness may release Dakota Wesleyan University from any financial responsibility or legal liability for pre-existing conditions.

I understand the information on this **DWU STUDENT HEALTH FORM** is an entrance requirement for DWU. This information will be treated with confidentiality within the offices of Dakota Wesleyan that may require this information. Offices include but may not be limited to Admissions, Student Life, the Arlene Gates Department of Nursing and the Athletic Department. I hereby authorize DWU to use information to meet the university requirements.

_____ _____

Student Signature Date

EMERGENCY TREATMENT CONSENT

FULL NAME _____ **DATE OF BIRTH** _____

In case of an accident or emergency in which I may be unable to direct my own medical care, I authorized Dakota Wesleyan University to seek appropriate medical/surgical care for me until those identified as emergency contact persons can be notified. I hereby state that the information on the **DWU STUDENT HEALTH FORM** is true, and I give permission for Dakota Wesleyan University to release information to healthcare providers and facilities who are included in my treatment. If under 18, this form must be signed by the student and the parent/guardian.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature Date

DAKOTA WESLEYAN UNIVERSITY

Student Health Form
REQUIRED IMMUNIZATION HEALTH HISTORY FORM

Required for you to proceed with class registration at Dakota Wesleyan University. Please print.

Full Name _____ Date of Birth ____ / ____ / ____
Last First Middle Initial Month Day Year

Home Address _____
Street Address City State Zip

Social Security No. ___ ___ ___ – ___ ___ – ___ ___ ___ ___ Student ID No. _____ Student's Cell Phone No. (_____) _____

Student's Email Address _____

THE INFORMATION BELOW MUST BE COMPLETED BY a healthcare provider BEFORE NEW STUDENT REGISTRATION. Copies of the complete vaccination record(s) are accepted in place of signature if accompanied by this form.

REQUIRED IMMUNIZATIONS

MMR required immunization for ALL students born after 01/01/1957 is required by South Dakota state law.

1. MMR (Measles, Mumps, Rubella) (2 doses required)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ OR

If given as separate doses, please identify:

2. Measles (Rubeola)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ OR

Mumps

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____

Rubella (German Measles)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____

3. Lab Titers Showing Immunity (Attach a copy of all lab results.)

Measles Titer Date _____ / _____ / _____

Mumps Titer Date _____ / _____ / _____

Rubella Titer Date _____ / _____ / _____

NOTE: If born before 1957, you are considered immune and require no further vaccination.

Tdap, Varicella and Hepatitis B (highly recommended for ALL incoming students; mandatory for nursing and athletic training majors)

1. Tetanus/Diptheria/Pertussis

Date Primary Series Completed: _____ / _____ / _____ Tdap Booster: _____ / _____ / _____

2. Varicella – Chicken Pox

History of Disease: ❑ Yes ❑ No OR Varicella Titer Date: _____ / _____ / _____ (Attach a copy of titer lab result.) OR

Immunization: Varivax Dose No. 1: _____ / _____ / _____ Varivax Dose No. 2: _____ / _____ / _____
If age 13 years or older, Varivax Dose No. 2 should be given at least one month after the first dose.

3. Hepatitis B (highly recommended for ALL; mandatory for nursing and athletic training majors – refer to immunization requirements for specific major)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ Dose No. 3: _____ / _____ / _____

4. Meningitis
Meningococcal Immunization: VACCINE OR SIGNATURE REQUIRED
Please read the following information at **www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html** and consult with your healthcare provider.

I have received information about meningococcal disease and choose **NOT** to receive the vaccine at this time.

_____ _____
Signature required if **NOT** receiving the vaccine. Date

I have received vaccine Menactra or Menveo (MCV4 Meningococcal Vaccination)

Dose No. 1: _____ / _____ / _____ Dose No. 2 (Booster): _____ / _____ / _____

I have received vaccine Menomune (MPSV4 Meningococcal Vaccination)

Dose No. 1: _____ / _____ / _____ Dose No. 2 (Booster): _____ / _____ / _____

5. Serogroup B Meningococcal

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____

OTHER VACCINATIONS TO CONSIDER

6. Hepatitis A (required for travel outside of the United States of America for mission or service-learning trips)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____

7. Quadrivalent Human Papilloma Vaccine (HPV)

Dose No. 1: _____ / _____ / _____ Dose No. 2: _____ / _____ / _____ Dose No. 3: _____ / _____ / _____

_____ _____
Physician's/Heathcare Provider's Signature Date

_____
PLEASE PRINT: Healthcare Provider's Name

_____
Healthcare Provider's Street Address City State Zip Phone No.

Mail Completed Form to:

Dakota Wesleyan University Health Services
1200 W. University Ave., Box 926
Mitchell, SD 57301