UWA | The UNIVERSITY of WEST ALABAMA

Student Medical Report and Immunization

Medical History: Completed by Student or Parent/Guardian

Student's Information

Name (Last, First): ______________________ Student ID: ______________

Address: ______________________ City, State, Zip: ______________

Date of Birth: ______________________ Phone: ______________

Email Address: ______________________________________

Semester Start: Year: __________ Circle One: Fall Spring Summer

Admission Status: Freshman Transfer Graduate Other: __________

Sex: ______ Race: ________ Height: ________ Weight: ________

Please mark Y (yes) and N (no) for each condition or activities.

	Y	N		Y	N
Seasonal Allergies			Gastric or Duodenal Ulcer		
Asthma			Colitis or Colon Problems		
Cancer			Rheumatic Fever		
Tuberculosis			Repeated Urinary Tract Infections		
Thyroid Disease			Epilepsy, Convulsions, or Seizures		
Diminished Hearing			Severe Headaches		
Abnormal Bleeding/Tenderness			Hepatitis		
Gall Bladder or Liver Disease			Diabetes		
Infectious Mononucleosis			Smoke		
High Blood Pressure			Drink Alcohol		
Congenital Heart Problems			Use Recreational Drugs		
Heart Disease			Other		
Severe Visual Problems					

Tuberculosis Risk:

**A TB Test will be required if you are determined to be at risk.*

Country of Birth:		
If born outside of the US, did you receive a BCG Vaccination? If yes, please provide proof.	Y	N
Have you lived in or traveled to another country for more than one month?	Y	N
If yes, list country and dates:		
Have you ever had close contact with anyone who was being treated for TB?	Y	N
If yes, list date/s:		
Have you had any of the following symptoms recently:		
Cough lasting 3 or more weeks, coughing up blood, night sweats, unexplained weight loss, unexplained fatigue?	Y	N
If yes, please explain:		
Have you worked with people who are at increased risk for TB?	Y	N
If yes, list date/s:		
Do you have a history of a positive TB skin test, blood test, or chest x-ray?	Y	N
If yes, please submit medical documentation, indicating proof test results and treatment plan.		

Are you allergic to any medications, foods, or other substances? If yes, please list. No ________ No _______

____

Any known physical restrictions? If yes, please list. No ________ ________

____

List ALL current medications:

Name of Medication	Dosage MG/ML	Frequency
1.		
2.		
3.		

Please list any other pertinent information regarding the status of your health: ______________________________

____

Name of family physician: ______________________________ Phone: ____________________

Address: ______________________________

City, State, Zip: ______________________________

To Be Completed By Student

I hereby affirm that all information supplied on this medical report is complete and accurate to the best of my knowledge. I understand that withholding information requested or giving false information may make me ineligible for admission and is reason for dismissal. I hereby give permission to the University Physician to render the evaluation and administer to me any medical aid as deemed necessary. I further authorize the use of x-rays, injections, casting, bracing, or other diagnostic tests and treatment as determined necessary. I also understand that, by signing this form, I am giving The University of West Alabama officials permission to obtain, prior to my enrollment and at any time during my enrollment, from any physician from whom I received treatment, any medical, prescription or psychological information that they feel necessary to determine my ability to function as a responsible The University of West Alabama student. I understand that my health information may be further released to other health care providers, hospitals and/or medical clinics and laboratories. Protected health information may be used and disclosed to carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for a description of uses and disclosures. I hereby acknowledge I have been offered and/or received a copy of the HIPAA Privacy Practices Notice.

** A person 18 years old or younger is considered a minor. If you are under 18 years old or younger, this form must be signed by your parent or legal guardian.

I hereby certify that I have read and understand this form and I accept all its terms.

Date: ______________ Signed ______________________________
Signature of Applicant

Date: ______________ Signed ______________________________
Signature of Parent/Guardian

*Optional (In accordance with the Privacy Act of 1974, you are not required to give your Social Security number.)

TO BE COMPLETED BY PARENT OR GUARDIAN OF A MINOR**

In the case of an emergency and/or upon recommendation of the University Physician that hospitalization is necessary to the welfare of my son/daughter, the University has my permission to admit him/her to the nearest hospital. University officials also have my permission to contact my son's/daughter's physician about his/her medial or psychological history and to administer any medical aid as deemed necessary.

Date: ______________ Signed ______________________________
Signature of Parent/Guardian

Address of Parent/Guardian: ______________________________

City, State, Zip: ______________________________

Phone: ______________________________

IMMUNIZATION REQUIREMENTS

Complete and Mail to: The University of West Alabama Office of Undergraduate Admissions Station #4 Livingston, AL 35470	**Or Email to:** admitme@uwa.edu **Or Fax:** 205.652.3881

Part 1 – TO BE COMPLETED BY THE STUDENT

Name: ______________________________________ Student ID: ______________________

Date of Birth: ________________________________ Phone: _________________________

Email Address: ____

Semester Start: Year ______________ Circle One: Fall Spring Summer

Admission Status: Freshman Transfer Graduate Other: _________________

Part 2 – TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER (All information must be in English)

REQUIRED Vaccinations:

A copy of the student's Department of Public Health Certificate of Immunization can be submitted or a lab report showing proof of immunity from measles (rubeola), mumps, and rubella can be submitted in lieu of the vaccine.

Measles, Mumps, Rubella (MMR) Vaccine Date of 1st dose: ___/___/____ Date of 2nd dose: ___/___/____
(*Refer to section below for specific guidelines*)

RECOMMENDED Vaccinations (not required)

Hepatitis B (3 doses) Dates of vaccines 1st ___/___/____ 2nd ___/___/____ 3rd ___/___/____

Varicella Dates of vaccines 1st ___/___/____ 2nd ___/___/____

Td Date of vaccine ___/___/____

Meningitis Vaccine Date of vaccine (within the last 5 years): ___/___/____ Type: ______________
(*Refer to section below for specific guidelines*)

______________________________ ______________________ ____________________________
Physician/Authorized Signature Date NPI License # or Clinic Stamp

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR) is required for all on-campus students entering UWA. The vaccination form must be completed in English and this form is the preferred document for proof of immunizations.

VACCINATIONS – The University requires all on-campus students born after 1956 to have had 2 doses of measles (rubeola) vaccine. One dose must have been a **Measles, Mumps, and Rubella** (MMR) vaccine.

A **Meningitis** (A, C, Y, W-135) vaccination within the past five (5) years is recommended for all on-campus students, especially those living in residence halls.

Please note: All students must submit completed Immunization form when applying. If a student has not fulfilled the requirements, this could hinder their acceptance. Students will not be allowed to start classes without the appropriate documentation on file. International Students and/or Individual Colleges, e.g. Division of Nursing, may have additional immunization requirements. These are general guidelines to be interpreted by the staff and subject to change based on the medical needs of the University.