Student Medical Report and Immunization Form

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					

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

_____

Any known physical restrictions? If yes, please list. Yes _____ 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:

_____

_____

Student Name: (Last, First) _____ Student ID: _____

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:	**Or Email to:**
The University of West Alabama Office of Undergraduate Admissions Station #4 Livingston, AL 35470	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:

Measles, Mumps, Rubella (MMR) Vaccine (Refer to section below for specific guidelines)

Date of 1st dose: ___/___/____ Date of 2nd dose: ___/___/____

Meningitis Vaccine (Refer to section below for specific guidelines)

Date of vaccine (within the last 5 years): ___/___/____ Type: _____

Required Tuberculosis Skin Test (within *6 months* of enrollment)

TB Test Date of Test ___/___/____ **Date of Reading** ___/___/_____Results: Positive_____mm Negative _____
***Note:** If positive, you must attach Radiology report from Chest X-Ray, negative blood test and/or documentation of treatment.

RECOMMENDED Vaccinations (not required):

Hepatitis B (3 doses) 1st ___/___/____ 2nd ___/___/____ 3rd ___/___/____
Varicella 1st ___/___/____ 2nd ___/___/____
Td ___/___/____ or **Tdap** ___/___/____

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), and Meningococcal / Meningitis is required, as well as negative Tuberculosis. This is a requirement for all on-campus students entering UWA. Both the vaccination form and negative Tuberculosis test results must be completed in English and this form is the preferred document for proof of immunizations. ***DO NOT SEND STUDENT'S "BLUE CARD" AS PROOF.**

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 copy of a lab report showing proof of immunity from measles (rubeola), mumps, and rubella can be submitted in lieu of the vaccine.

A **Meningitis** (A, C, Y, W-135) vaccination within the past five (5) years is required for all on-campus students.

A negative **Tuberculosis Test** is required of all on-campus students. Students who are found to have a positive test will not be permitted to attend classes until follow-up testing can be completed and it is determined there is no active Tuberculosis disease.

Please note: All students must submit completed Immunization / Tuberculosis forms and supporting documentation 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. 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.