WHEELING UNIVERSITY

Doctor of Physical Therapy

Pre-Entrance Health Record

Completed health forms and additional requirements must be received by the Student Health Center by August 3, 2020.

PLEASE PRINT CLEARLY

Name: _____ _____ _____ Sex: ○ Male ○ Female
LAST FIRST MIDDLE

Date of Birth:: ___/___/_____ Email that you check regularly: _____
MM DD YYYY

Student Cell Phone: (_____)_____ Student Home Phone: (_____)_____

Address: _____ City: _____ State: ___ Zip: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ City: _____ State/Country: _____ Zip: _____

Home Phone: (___)_____ Alternative Phone: (___)_____ Emergency Contact Email: _____

Family Physician / Health Care Provider:: _____ Phone: (___)_____

Address: _____ City: _____ State/Country: _____ Zip: _____

MANDATORY AUTHORIZATIONTO RENDER HEALTH SERVICES.

I hereby authorize Wheeling University's Student Health Center to render services deemed necessary for my health and well-being. I grant permission for my transfer to an accredited hospital or other care facility if deemed necessary by the VP of Student Services or his/her designee. I agree to be responsible for any expense in connection with the aforesaid, if my insurance does not provide payment of the same. I grant permission for the hospital or other care facility to provide information concerning my treatment by their facility to Wheeling University's Health Center for continuity of care.

Student Signature: _____ Date: _____

ANNUAL MEDICAL INSURANCE COVERAGE REQUIREMENT

This requirement is to ensure that all students will have access to medical care, if needed. Your medical insurance information will be kept confidential and on file for scheduling medical referrals to outside physicians, outpatient treatment, emergencies, and participation in the Doctor of Physical Therapy Program at Wheeling University.

Please submit a clean readable copy and a letter of verification with start and end dates of coverage. You are required to provide current insurance information whenever there is a change.

ANNUAL PHYSICAL REQUIREMENT

It is mandatory that all students in the Doctor of Physical Therapy Program at Wheeling University submit an annual physical. **Your initial physical is required to be dated after July 1 and received by the Health Center by August 3, 2020.**

Completed health forms and additional requirements must be received by the Student Health Center by August 3, 2020.

You are required to make a copy of all of your documents before mailing them to the Student Health Center.

Mail to: The Student Health Center
Wheeling University
316 Washington Ave.
Wheeling, WV 26003

For questions or concerns, please call: 304-243-2225 or
email: healthcenter@wju.edu (put your name and major in the subject line)

Personal Health History

This information will be used only as an aid in the consideration of your health needs and will remain confidential among the appropriate healthcare professionals. PLEASE USE ADDITIONAL SHEETS OF PAPER IF NECESSARY.

Are you presently under any medical treatment? ❍ Yes ❍ No
If yes, explain: _____

Are you presently taking any medications (prescription, nonprescription, inhaler)? ❍ Yes ❍ No
If yes, explain: _____

Are you now receiving or have you ever received professional help for emotional or psychological problems? ❍ Yes ❍ No
If yes, when: _____

Do you have a physical impairment such as paralysis, loss of vision, loss of hearing, etc.? ❍ Yes ❍ No
If yes, explain: _____

Do you have any sensitivity to food, medicine, or environmental contact? ❍ Yes ❍ No
If yes, explain: _____

Have you ever had a head injury or concussion? ❍ Yes ❍ No
If yes, explain and give dates: _____

Has a physician ever denied or restricted your participation in sports for any health problems? ❍ Yes ❍ No
If yes, explain: _____

Have you ever had, or do you currently have (CHECK ALLTHAT APPLY):

❍ Anemia
❍ Anxiety
❍ Asthma/Exercise Induced Asthma
❍ Bladder/Kidney Problems
❍ Bleeding Disorders
❍ Blood Clots (Leg/Lung)
❍ Cancer (Type _____)
❍ Cardiac Disease (Type _____)
❍ Chicken Pox
❍ Depression
❍ Dermatological Issues (Type _____)
❍ Diabetes (Hyperglycemia/Hypoglycemia)
❍ Fractures (Broken Bones) Where? _____
❍ Gallbladder Disease
❍ Gastrointestinal Issues (Heartburn/GERD/Irritable Bowel)
❍ Gynecological Issues
❍ Mononucleosis
❍ Seizures
❍ STDs
❍ Suicidal/Homicidal Ideation
❍ Thyroid Disease (Hyperthyroidism/Hypothyroidism)

If you checked any of the above, please provide further information: _____

Dates of significant injuries or operations or medical admissions to hospitals: ❍ NONE _____

Personal Habits (please indicate use of any of the following):

Tobacco Use: ❍ Never ❍ No ❍ Yes Quit Date: _____ How many years did you smoke? _____

Current Smoker: Packs/day: _____ # of years: _____ Other tobacco: ❍ Pipe ❍ Cigar ❍ Snuff ❍ Chew

Alcohol Use: Do you drink alcohol? ❍ No ❍ Yes # of drinks/week: _____ ❍ Beer ❍ Wine ❍ Liquor

If you wish to receive care for any health problem or concern at the WU Student Health Center, please bring copies of any appropriate medical records with you to campus and call (304) 243-2275 for an appointment.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Student Name (please print): _____ Signature: _____ Date: _____

Completed health forms and additional requirements must be received by the Student Health Center no later than August 3.

In case your records are not received, please make a copy of all of your documents before mailing them to the Student Health Center.

Mail to: The Student Health Center
Wheeling University
316 Washington Ave.
Wheeling, WV 26003

For questions or concerns, please call: 304-243-2275
or email: healthcenter@wju.edu (put your name and major in the subject line)

Insurance, Immunizations, Lab work, Tuberculin Skin Tests

PLEASE BE MINDFUL THAT SOME REQUIREMENTS ARE TO BE COMPLETED DURING A SPECIFIC TIMEFRAME.

An accurate record of immunizations is required for all health science majors. This can be obtained from your private physician/healthcare provider or health department. Your Board of Education is one source for official proof of primary records. You can also get any needed immunizations and tuberculin skin tests administered at any of your local walk-in type urgent care clinics.

Below is a list of additional requirements. Please attach official documentation of each requirement to your health form and submit them together.

You must meet the required submission deadline of August 3, 2020 to give the Student Health Center time to review your records for accuracy. The Student Health Center will then have time to alert you of any deficient records, if any, so that you will have time to bring all requirements up-to-date before you attend classes.

1) **Proof of health insurance coverage**. A photocopy of your card (front and back) **AND** a letter of coverage from your insurance provider. You will be expected to maintain health insurance coverage at all times while enrolled as a student at WU. Your medical insurance information will be kept confidential and on file for clinical rotations, scheduling medical referrals to outside physicians, outpatient treatment, and for emergencies.

2) **Immunizations AND titers (blood work):** You can get documentation of immunizations from your doctor *OR* check with your previous school to see if they have a record on file. You can also get any needed immunizations through a county health department or a walk-in urgent care type clinic.

IMPORTANT NOTE ABOUT YOUR TITERS: Complete all titers before July in case there is a need to be retitered – this timeframe is to ensure that you will meet requirements before starting classes. If a titer shows no evidence of immunity, your doctor will administer a booster and then retiter after about 4-8 weeks to see if the booster provided immunity. Your doctor may also suggest restarting a vaccine series.

- MMR (measles, mumps, rubella) 2 dose vaccine series AND a titer (blood work) for each
- Hepatitis B - 3 dose vaccine series AND a titer (blood work). If you have not had the 3 dose vaccine series, please start the process, as soon as possible. You should have time to complete the first two doses before starting class. During this process you will be considered in 'conditional status' while waiting to get the 3rd (final) dose. You must schedule a titer once you've completed the series.
- Varicella - 2 dose vaccine series *or* documentation that you have had the disease AND a titer (blood work), regardless of having had the disease or vaccine series.
- Tdap (tetanus, diphtheria, acellular pertussis), 1 dose - Important note: A Tdap vaccine is only good for 10 years. Please make sure that your vaccine is current and will not expire during the course of your WU studies and clinical rotations.
- Polio - 3 dose vaccine series
- Meningococcal - This vaccine is strongly recommended. Please visit the Center of Disease Control website (www.cdc.gov) to read the VIS for MCV4. If you choose not to receive this vaccine, you must sign the WU Meningococcal Release included in this packet.

Important! All of the above items (health forms, insurance, required immunizations, and titers (bloodwork)) are due on or before August 3.

3.) Physical (a form is included in this packet). Your physical should be completed between July 1 and August 1 so that your annual due date does not conflict with your first clinical rotation. Submit on or before August 3.

4.) Two-Step TST (tuberculin skin test): Your TST should be completed between July 1 and August 1 so that your annual due date does not conflict while out on your first clinical rotation. Please note: a BCG vaccine or an assessment questionnaire will not be accepted. A chest x-ray or blood test will be accepted *if* there is documented medical evidence as to why you cannot receive the skin test. Submit on or before August 3.

The TST is not an immunization, so you may never have had one before. This skin test is a method of determining whether a person is infected with Mycobacterium tuberculosis. A two-step testing is useful for the initial skin testing of adults who are going to be retested periodically. This two-step approach can reduce the likelihood that a boosted reaction to a subsequent TST will be misinterpreted as a recent infection.

The second step is placed 1-3 weeks after the first step is read. You will expect to return to your doctor within 48-72 hours after each TST so that your arm can be checked for the result. If your result is positive, please provide your doctor's plan of treatment. Failure to have the result documented for each step will mean that you will have to repeat the test. Please note: if you find it difficult to get an appointment with your doctor to provide this test, you can also get it through your county health department or a walk-in urgent care type clinic. These options will help you to meet your deadline.

MENINGOCOCCAL VACCINE WAIVER FORM

A few years ago, research by the Center for Disease Control (CDC) found that students appear to be at higher risk for meningococcal disease than college students overall. The College and University Student Vaccination Act has been in effect in many states since. It states that all students residing in campus housing receive a one-time vaccination against meningococcal disease or sign a waiver for religious or other reasons after they have been provided with information on the risks associated with the disease and the effectiveness of the vaccine. Given the seriousness of meningococcal disease, Wheeling University strongly recommends that all students receive a vaccination against this meningitis, regardless of their residential status. Any student choosing not to receive this vaccination must sign this waiver indicating that they understand the risks associated with meningococcal disease and the availability and effectiveness of the vaccine.

What is meningitis?

Meningitis is an infection of the fluid of a person's spinal cord and the fluid that surrounds the brain. People sometimes refer to it as spinal meningitis. Meningitis is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ. Viral meningitis is generally less severe and resolves without specific treatment, while bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disability. For bacterial meningitis, it is also important to know which type of bacteria is causing the meningitis because antibiotics can prevent some types from spreading and infecting other people. Before the 1990s, *Haemophilus influenzae* type b (Hib) was the leading cause of bacterial meningitis, but new vaccines being given to all children as part of their routine immunizations have reduced the occurrence of invasive disease due to *H. influenzae*. Today, *Streptococcus pneumoniae* and *Neisseria meningitidis* are the leading causes of bacterial meningitis. This information has been taken from the Center for Disease Control website. We encourage students to visit < http://www.cdc.gov/> to receive more information about meningitis before signing this waiver.

STUDENT RELEASE UPON REFUSAL
OF IMMUNIZATION AGAINST MENINGITIS

I understand that it is recommended that all university students receive the vaccination against meningococcal disease. I understand that by declining this vaccine, I continue to be at risk of acquiring meningitis, a serious disease. I, also, understand that the majority of clinical placement sites are requiring evidence of meningococcal disease immunity before accepting health science students for clinical practice and I acknowledge that, if I do not have evidence of this immunity, my placement for clinical practice may be affected (if applicable).

Despite the risks described above, I request that my refusal be honored, and I hereby release Wheeling University, its officers, trustees, employees and agents as well as any clinical agency in which I practice due to any student role from any and all liability that may arise directly or indirectly as a result of my refusal of the meningococcal disease vaccine.

I, _____ refuse immunization against meningitis.
(Print name)

Signature:_____ Date: _____

Doctor of Physical Therapy

YOUR PHYSICIAN OR NURSE PRACTITIONER
MUST COMPLETE, SIGN, AND DATE THIS FORM.

PLEASE PRINT

STUDENT NAME: _____ _____ _____ DATE OF BIRTH: _____
Last First Middle Initial

Family history: Among your immediate relatives (parents, siblings and grandparents), is there any history of, or present illness from, any of the following:

- Cancer
- Diabetes
- Asthma, Hay Fever, or other Allergies
- Heart Disease
- Marfan's Disease
- Sudden death under age 50 from non-trauma cause

Please explain any of the marked replies: _____

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

LIST MEDICATIONS: _____

Normal	Abnormal	Notes of Abnormality
_____Skin	_____	
_____Hearing	_____	
_____Head	_____	
_____Ear, Nose, Throat	_____	
_____ Neck: Thyroid	_____	
_____Cardiovascular	_____	
_____Lungs	_____	
_____Breasts	_____	
_____Abdomen	_____	
_____Genitalia	_____	
_____Menstruation	_____	
_____Back & Extremities	_____	
_____Reflexes	_____	

_____ Student must be able to lift up to 50 pounds. Does this student meet this qualification? _____

ALLERGIES/REACTIONS: No known allergies: _____

Latex: _____ food: _____

dyes: _____ medication: _____

(REQUIRED RESPONSE) Does this student have any past or current physical or emotional conditions that you consider important?
_____

(REQUIRED RESPONSE) Is this student presently under medical therapy or psychological counseling? _____

Recommendations: _____

Name of Physician OR NP (print): _____

Phone: [____]_____ Fax: [____]_____

Address: _____(City)_____(State)___ (Zip) ____

Signature of Physician OR NP: _____ Date: _____

This Form is to be Completed by a Licensed Medical Professional

NAME (please print): (Last)_____ (First)_____ (Middle Initial) _____ DOB: _____

ATTACH ORIGINAL COPIES TO SUPPORT THE FOLLOWING INFORMATION.

STRONGLY RECOMMENDED: MCV4 Vaccine (meningococcal conjugate vaccine) (1 dose) month _____ day _____ year_____
Student refused this vaccine. Yes ___ No ___

REQUIRED: Polio Vaccine (3 dose series)
Dose #1: month _____ day _____ year _____ ; Dose #2: month _____ day _____ year _____; Dose #3; month _____ day _____ year _____

REQUIRED: Hepatitis B Vaccine (3 dose series)
Dose#1: month _____ day _____ year _____; Dose#2: month _____ day _____ year _____; Dose:#3: :month _____ day _____ year _____
AND a titer that shows evidence of immunity

REQUIRED: Tdap Vaccine (tetanus, diphtheria, acellur pertussis): 1 Dose within the last ten years: month _____ day _____ year _____

REQUIRED MMR Vaccine (measles, mumps, rubella) (2 doses) Dose #1: month ____ day ____year ____ Dose #2: month ____day ____year____
AND a titer that shows evidence of immunity

Varicella Vaccine (chicken pox) Has this student had the disease? ""yes ""no _____approximate year of having disease
Has student had varicella vaccine (2 doses)? ___yes __no Not required unless the required titer report shows no evidence of immunity.
Dose #1: month _____ day _____ year _____ Dose #2: month _____day _____ year____ *AND* a titer that shows evidence of immunity

Mandatory Antibody Titer Results for: measles result _____ mumps result _____ rubella result _____ varicella result _____ hepatitis result _____
If any titer does not show immunity, please attach follow-up plan of actions and documentation(s).

Note: *In order to participate in service learning experiences these results must be complete and received in the Health Center no later than August 3.*

REQUIRED Tuberculosis Screening
Two-Step PPD (purified protein derivative) Skin Test
1st of Two-Step Placed: month ____ day ____ year ____; Read: month ____ day ____ year ____ Result in millimeters ____mm
2nd of Two-Step Placed: month ____ day ____ year ____ ; Read: month ____ day ____year ____ Result in millimeters ____mm

Or ATTACH a chest x-ray report if the student has had a history of a previous PPD.

Signature of Physician or Nurse Practitioner _____ Print Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Date: _____

Please attach documentation for all required immunizations,
both tuberculin skin tests, and required antibody titer reports.