

**WESTERN OREGON UNIVERSITY
STUDENT HEALTH and COUNSELING CENTER
HEALTH HISTORY**

Please return completed form to the Student Health and Counseling Center at Western Oregon University
345 North Monmouth Avenue, Monmouth OR 97361 Fax: 503 838-8801 Telephone: 503 838-8313

LAST NAME FIRST MIDDLE

NAME OF PARENT, GUARDIAN or SPOUSE

CAMPUS / LOCAL ADDRESS, IF KNOWN

HOME ADDRESS of PARENT, GUARDIAN or SPOUSE

CITY STATE ZIP

CITY STATE ZIP

Sex: Male ___ Female ___

Person to be notified in case of emergency:

Cell or School Phone _____

NAME RELATIONSHIP TO STUDENT

Social Security No. _____

TELEPHONE NUMBER

Student ID No. _____

Date of Birth _____ Age _____

State or Country of Birth _____

Term entering WOU _____

PERSONAL AND FAMILY HISTORY (check YES answers only)

	You	Family	Please explain
Alcoholism / Drug Abuse			
Allergies / Environmental			
Anemia or Blood Disease			
Asthma			
Cancer			
Diabetes			
Gastrointestinal Disorder			
Head Injury			
Hearing Loss			
Heart Disease			
Hepatitis			
High Blood Pressure			
Kidney Disease			
Mental Illness (depression, anxiety eating disorders)			
Muscle / Joint Disease			
Rheumatoid Arthritis			
Seizure Disorder			
Thyroid Disease			
Tuberculosis			

Allergies to medication(s) _____

Medical Problems currently under treatment _____

Prior surgeries (types and dates) _____

Chronic illness / or disabilities _____

(for accommodations contact Disability Services at 503 838-8250)

Drugs / Medicines you use regularly (includes contraceptives, herbal medicine) _____

STUDENT SIGNATURE

DATE

CLEARED

MMR Date _____

Initials _____

IMMUNIZATION HISTORY

YOU WILL NOT BE ALLOWED TO COMPLETE YOUR REGISTRATION OR ATTEND CLASSES IF DOCUMENTATION IS NOT RECEIVED.

REQUIRED IMMUNIZATIONS: Measles (Rubeola/Hard Measles – 2 doses)

Each student who was born on or after January 1, 1957 must have two doses of measles vaccine:

1. Two doses (documented by month and year of each dose) on or after the first birthday, with a minimum of 30 days between the doses; or
2. No available documentation for the month and year of the first dose but documentation of the month and year of the second dose on or after December, 1989. International students need documentation for both dates.

Accepted documentation is:

- Doctor's office or medical clinic records. International Students, please have records in English.
- Public Health Department records
- Personal immunization card (signed by clinic staff)
- Your high school or previous college immunization records

TO PROVIDE DOCUMENTATION OF YOUR MEASLES IMMUNIZATIONS, STAPLE A COPY OF YOUR IMMUNIZATION RECORDS TO THIS FORM.

The following immunizations are not required, but are recommended for continued good health.

- A Diphtheria/Tetanus (Booster dose within last 10 years)
- B Polio
- C Hepatitis A Series (two doses)
- D Hepatitis B Series (three doses)
- E Meningococcal-Menomune or Menactra (one dose)
- F Varicella (chicken pox)
- G Rubella (German/3-day Measles)(one dose)
- H Mumps (one dose)

AGE, MEDICAL OR RELIGIOUS EXEMPTION FOR TWO-DOSE MEASLES VACCINE

AGE EXEMPTION

I was born before January 1, 1957 and am therefore considered immune

Date of birth (month/day/year) _____

STUDENT SIGNATURE

DATE

RELIGIOUS EXEMPTION

I have read and understood the information on this form. I am an adherent to a religion or philosophy whose teachings are opposed to immunization, and I therefore request that I be exempted from the immunization requirement.

STUDENT SIGNATURE

DATE

MEDICAL EXEMPTION

I certify the above-named student should be exempted from the requirements for the measles vaccine based on:

A History of measles (month/year) _____

B Immune titer shows immunity to measles (month/year) _____

C The following medical reason _____

Constitutes a medical contraindication in accordance with the advisory committee on immunization practices of the U.S. Public Health Service for measles vaccine.

SIGNATURE OF HEALTH CARE PRACTITIONER

DATE

PRINTED NAME & TITLE OF HEALTH CARE PRACTITIONER

DATE