Please attach copy of health insurance card and full immunization records

MEDICAL FORM

Full Name: ______________________________ M:____ F:____
Address: ______________________________
______________________________ DOB: ______________
Cell Phone: ______________ Email: ______________
Parent Name(s): ______________________________
Parent(s) Cell Phone: ______________________________
Health Insurance Co. ______________________________
Emergency Contact Name: ______________________________
Emergency Contact Number: ______________________________

STUDENT HEALTH HISTORY: PLEASE CHECK ALL THAT APPLY AND EXPLAIN RESPONSES BELOW

Abnormal Bleeding		Drug Use		HIV		Seizures	
Alcohol Use		Ear Trouble/Hearing Loss		Intestinal Trouble		Sexually Transmitted Infection	
Anemia		Eating Disorder		Irritable Bowel Syndrome		Sickle Cell Disease/Trait	
Anxiety		Eye Trouble/Visual Loss		Joint Problems		Skin Disorder	
Asthma		Fainting		Liver Problems		Sleep Problems	
ADD/ADHD		Genetic Disorder		Menstrual Problems		Thyroid Disease	
Cancer		Headaches – (frequent)		Missing Organs		Tobacco Use	
Chest Pain		Heart Murmur		Mononucleosis		Tooth/Gum Problems	
Chicken Pox		Heart Problems		Orthopedic Conditions		Tuberculosis	
Concussion		Heat Stroke		Pelvic/Vaginal Infections		Ulcer	
Depression		Hernia		Psychological Disorder		Undescended Testicle	
Diabetes		High Blood Pressure		Rheumatic Fever		Urinary Tract Problems	
Digestive Disorder		High Cholesterol		Scoliosis		Weight Loss/Gain	

Explain checked responses: ______________________________
____
____

	Age	State of Health	Cause of Death
Father			
Mother			
Siblings			

Have any of your relatives ever had the following:

	YES	RELATIONSHIP
Alcoholism		
Asthma		
Diabetes		
Heart Disease		
Mental Illness		
Sudden Unexplained Death		
Other:		

Have you ever been hospitalized or had any serious illness, injury or surgery; (please explain) ______________________________
____
received treatment or counseling for mental health reasons including substance abuse; (include dates and provider name)______________
____
been unable to participate in sports/gym class for longer than a few days? (please explain)______________________________
____

Medications and Dosage Taken: (including herbals, vitamins, supplements, and birth control) ______________________________
____
____
____

Allergies: (including to medicines) ______________________________
____
____
____
Receiving Shots? ________How often? ______________

The above information is accurate to the best of my knowledge. In the case of serious injury or illness, I authorize Wells College representative(s) to secure medical care and/or hospitalization on my behalf. I authorize Health Service personnel to perform routine medical care as deemed necessary and to release information pertaining to safe participation in athletics to the athletic trainer. I have reviewed information on Meningitis and the vaccine at https://www.wells.edu/student-life/medical-center, and

☐ **I do not want the vaccine;** ☐ **I have an appointment to receive the vaccine;** ☐ **I received the vaccine within the last 5 years.**

STUDENT SIGNATURE________________ **DATE** _______ **PARENT SIGNATURE**______________________ **(IF UNDER 18) DATE** _______

WELLS COLLEGE PHYSICAL FORM

To be Completed by the Examining Healthcare Provider

PATIENT NAME ______________________________
DATE of EXAM ______________________________

Height: _________ Weight: _________ BP: ___________

Pulse:___________ Temp:___________

Vision: Right 20/ ____ Left 20/ ____ Both 20/____ Corrected or Uncorrected

Urinalysis: Normal ________________ Abnormal Values ________________

	Check items as examined, enter "NE" if not evaluated	Normal	Abnormal	Give details of each abnormality, use item number
1	Head, Neck, Face, Scalp			
2	Nose and Sinuses			
3	Mouth, Teeth, Gingiva, Throat			
4	Ears – Canals, TM's, Hearing			
5	Eyes – Lids, Pupils, Fundoscopic, etc.			
6	Lungs, Chest			
7	Breasts			
8	Heart – Rate, Rhythm, Extra Sounds			
9	Abdomen			
10	Endocrine System			
11	Genito-Urinary System – Testicular Exam, if male			
12	Upper Extremities			
13	Lower Extremities			
14	Spine, Other Musculoskeletal Structures			
15	Skin and Lymphatics – Acne, Dermatitis, etc			
16	Neurological System			
17	Gynecologic history – LMP Date________________ PAP Date ____________			
18	Psychological Status			

Recommendation for Physical Activity: ☐ Unlimited ☐ Limited ____________________________ ☐ Disqualified for Sports

Provide any recommendations for care of this student while away at college: ______________________________

Is this student currently under treatment for any medical or mental health condition? ☐Yes ☐No

Diagnosis:____

Is this student currently on any medications, including birth control? (please list) ______________________________

Does this student require special housing or dietary accommodations while away at college? ☐Yes ☐No

If yes, give reason and supporting diagnosis ______________________________

Has the Immunization Record been reviewed for required and recommended vaccines (and attached to this form)? ☐Yes ☐No

Has the Medical History Form been reviewed with the patient? ☐Yes ☐No

Stamp or Print Name:______________________________ Provider Signature: ______________________________

Address: ____

Phone: ______________________________ Date: ______________________________

PLEASE SUBMIT THIS FORM WITH THE REQUESTED ATTACHMENTS TO THE ADMITTED STUDENT PORTAL AT https://apply.wells.edu/account/login