

PART II NOTICE OF PRIVACY PRACTICE FORM

Attached to this form is a copy of Nebraska Wesleyan University's notice of Privacy Practice (HIPAA) form.

PART III IMMUNIZATION HISTORY

In accordance with the Department of Health of the State of Nebraska, Nebraska Wesleyan University requires students to show current proof of immunization for the following:

Proof of two doses of live measles vaccine given after the age of 12 months is required of all students born after 1957.

Requirements for Immunizations

NE Law 79-444.01 requires that each student shall be protected against Measles, Mumps, Rubella-**(TWO IMMUNIZATIONS REQUIRED)**, Poliomyelitis, Diptheria, Pertussis and Tetanus (DPT) by immunization prior to enrollment.

A lab report of having the disease is acceptable.

Mandatory Immunization

Nebraska Wesleyan will require, beginning with students enrolling in the 2005-2006 academic year, meningococcal (meningitis) immunization, either prior to enrollment or provided at cost through NWU Student Health within 30 days of enrollment.

Dates Given (month and year)

(Shaded area indicates number of shots required.)

	#1	#2	Nursing Students Only	
(If given separately)			TB - mautou	_____
Mumps (Red/Hard Measles)			Rubeola Titer	_____
Rubeola (3 day/German Measles)			Rubella Titer	_____
Rubella (given together)			Varicella Shot	_____
MMR				
Meningitis			Titer Date	_____
	#1	#2	#3	#4
(If given separately)				
Diptheria				
Pertussis				
Tetanus				
(If given together)				
DPT/Td				
Poliomyelitis (OPV or IPV)				
Hepatitis B				
Other	_____			
	(e.g., Hepatitis A, Hib, Malaria)			

PART IV EMERGENCY INSTRUCTIONS

If emergency treatment is necessary, may the University authorities use their judgment in obtaining medical care for you? **(EVERY ATTEMPT WILL BE MADE TO CONTACT THE PARENTS IN CASE OF HOSPITALIZATION AND/OR EXTENSIVE TREATMENT.)** (Please indicate choice below.)

If answer is Yes, permission is hereby given to administer recommended medical treatment, diagnostic studies and immunization. Once again, every effort will be made to contact the parent in case of serious illness or if surgery and/or extensive laboratory testing is indicated.

If answer is No, what should be done? _____

If you have any questions or notes which may be helpful to our Student Health and Wellness Center, please attach a separate page with that information.

Student's Signature _____

Consent by parent or guardian if student is under 19 years of age: Signature required that information provided has been received and reviewed.

Parent's Signature _____ Date _____

IMPORTANT! Mail the completed form to:
Student Health and Wellness Center • Nebraska Wesleyan University
5000 Saint Paul Avenue • Lincoln, Nebraska 68504-2794

Nursing Students, mail the completed form to:
Nursing Program • Nebraska Wesleyan University
5000 Saint Paul Avenue • Lincoln, Nebraska 68504-2794



Name _____ Please circle Current College Year 1 2 3 4
 Social Security Number _____ Date of Birth ____/____/____ Age _____ Sex _____
 Home Address _____ (street or box) _____ (city) _____ (state) _____ (zip)
 Home Phone _____ Work Phone/Mother _____ Father _____
 Relative to Notify in Case of Emergency _____ Phone _____
 Family Physician _____ Health Insurance Company _____
 Clinic # _____

Please attach a photocopy of insurance card (both sides)

PART I
FAMILY HISTORY

Name/Occupation	Age (if living)	State of Health	Age & Year of Death	Significant Illnesses or Cause of Death
Father _____				
Mother _____				
Siblings _____				
Spouse _____				
Children _____				

Are there any familial, hereditary or prevalent diseases in your family? (e.g. alcoholism, allergies, cancer, high blood pressure, kidney disease, stroke.)
 List diseases and relationship of those family members. _____

PERSONAL HISTORY

	Yes *	No
Have you had....?		
Acute infectious diseases		
Chicken Pox		
Hepatitis		
Infectious Mononucleosis (mono)		
Pneumonia		
Tonsillitis		
Typhoid		
Meningitis		
Other		
OTHER DISEASES		
Alcoholism/drug addiction		
Anemia		
Anorexia/Bulimia		
Asthma		
Cancer		
Chronic Bronchitis		
Chronic skin disease (e.g. eczema, psoriasis)		
Convulsions, seizures (epilepsy, narcolepsy)		
Dental problems		
Diabetes		
G.I. Disease (e.g. GERD, Hiatal hernia, colitis)		
Glaucoma		
Hay fever/Allergies		
Heart disease (Rheumatic fever, murmur)		
High blood pressure		
Kidney or bladder disease—Urinary Tract Infection		
Other		

	Yes *	No
Malaria		
Orthopedic problem (e.g. knee, back, shoulder)		
Prolonged depression or anxiety		
Speech, hearing, vision problem		
Severe headache (e.g. migraine)		
Thrombophlebitis DVT or Blood Clots		
Thyroid or Endocrine disturbance		
Tuberculosis, History of		
Sleep disturbance (apnea, walking in sleep)		

OTHER HEALTH CARE HISTORY

Have you been hospitalized?		
Have you had any surgical operations?		
Are you under medical treatment?		
Do you take any prescribed medicine or injections?(see below)		
Do you have a physical, mental or learning handicap?		
Are you under care of State Rehabilitation?		
Have you been advised to seek psychological help?		
Have you received psychological care?		
Have you traveled outside the U.S.? Where? When?		
MENSTRUAL HISTORY (females only)		
Problems (e.g. cramps, irregular, excessive flow)		
Oral contraceptives		
Female infections		
Pregnancies		
Termination of pregnancy		

* **Comment on all yes answers to above questions:**

Height _____ Weight _____ Blood Pressure (Optional) _____

ALLERGIC REACTIONS: (e.g. penicillin, sulfa, food, immunization, environmental):

If not enough room, attach list to this page (e.g.:Meds, surgery, etc.)