# Weimar Institute Nursing Department
# HEALTH INFORMATION FORM

*Student fills out this section (Pages 1 and 2).*

All information must be completely filled our before submitting. Your health information and medical records are kept confidential.

Check one of the following: _____First Year (never attended Weimar College)
_____ Returning Student (last school year attended_____) Student ID # _____

**PLEASE PRINT IN INK**

Full Legal Name_____
Last First Middle Maiden

Date of Birth _____ Sex_____ Social Security Number_____

Home Address _____ Phone _____
Number, Street City State Zip Code

**Relative or person to be notified in case of emergency:**

Name _____ Relationship _____Home Phone _____

Address _____Work Phone _____
Number, Street City State Zip Code

**Person to be notified in emergency (on campus)**Name_____ Phone _____

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**Insurance Information (attach copy of front and back of your primary insurance card)**

Do you have insurance _____ No _____ Yes

Primary Insurance Company Name _____Insured Party's (Policy Holder) Name _____

Relationship to Student _____ Policy Number _____

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List all medications taken regularly _____

List any allergies to medication _____

List all major injuries/hospitalizations: _____

**Documentation for each of the following IMMUNIZATIONS (attach copy of immunization records)**

□ DTaP including last tetanus □ Polio □ MMR (within last 10 years)
□ TB test within last year □ Varicella □ Hepatitis B

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**Personal History:** Check (x) on line indicating you have had the following and give date, if applicable.

| | | | |
|---|---|---|---|
| __ ADD/ADHD<br>__ Alcoholism<br>---- Allergy<br>---- Anemia<br>---- Arthritis<br>---- Asthma<br>---- Back Trouble<br>---- Brain Concussion<br>---- Cancer<br>---- Chickenpox<br>---- Colds-frequent<br>---- Colitis<br>---- Constipation | ---- Diabetes<br>---- Eating Disorder<br>---- Eczema<br>---- Epilepsy<br>---- Fainting Spells<br>---- Fatigue<br>---- German Measles<br>---- Glandular Disorder<br>---- Hay Fever<br>---- Headaches<br>---- Hepatitis<br>---- Hernia or Rupture<br>---- High Blood Pressure | ---- Influenza<br>---- Jaundice<br>---- Measles<br>---- Meningitis<br>---- Mental Illness<br>---- Mononucleosis<br>---- Mumps<br>---- Nervousness<br>---- Pneumonia<br>---- Poliomyelitis<br>---- Rheumatic Fever<br>---- Scarlet Fever<br>---- Sinusitis | ---- Sleeplessness<br>---- Sore Throat (Frequent)<br>---- Suicide Attempts<br>---- Tonsilitis<br>---- Tuberculosis<br>---- Typhoid<br>---- Ulcers (stomach or duodenal)<br>---- Whooping Cough<br>---- Born or raised in foreign country. Where?_____<br><br>---- Other _____ |

**FAMILY HISTORY**: Check the illnesses your BLOOD RELATIVES now have or have had. (Indicate which relative.)

| | | | |
|---|---|---|---|
| ___ ADD/ADHD<br>___ Alchoholism<br>___ Allergies<br>___ Anemia<br>___ Arthritis<br>___ Asthma<br>___ Bleeding Trait | ___ Cancer<br>___ Colitis<br>___ Congenital Defect<br>___ Depression<br>___ Diabetes<br>___ Epilepsy<br>___ Heart Disease | ___ High Blood Pressure<br>___ Kidney Disease<br>___ Leukemia<br>___ Mental Illness<br>___ Migraine Headaches<br>___ Nervous Breakdown<br>___ Obesity | ___ Peptic Ulcer<br>___ Sickle Cell Anemia<br>___ Suicide or Attempts<br>___ Thyroid Disease<br>___ Tremors, Palsy<br>___ Tuberculosis<br>___ Other _____ |

**TREATMENT AUTHORIZATION FOR PERSONS OVER 18 YEARS OF AGE**

I give my permission to the Weimar Center of Health and Education Medical Clinic and its staff to provide necessary medical care in the event of an illness/injury sustained while I am a student. I also authorize obtaining pertinent medical information from my primary care provider if indicated.

Date _____ Applicant's Signature _____

**TREATMENT AUTHORIZATION FOR PERSONS UNDER 18 YEARS OF AGE**

(I) or (We) the undersigned parent(s) (guardian(s) do hereby give permission to the Weimar Center of Health and Education Medical Clinic and its staff to provide necessary medical care in the event of an illness/injury sustained by our child. Our signature also gives authorization to obtain pertinent medical information from our child's primary care provider if indicated.

Date _____Parent/Guardian's Signature _____

## Weimar Institute Nursing Program

# PHYSICAL EXAMINATION

*To be filled out by Physician, Physician Assistant or Nurse Practitioner*

Please complete the physical examination form and note any current or recent immunizations and any significant laboratory or x-ray findings. The following are required: negative TB skin test or chest x-ray, urinalysis and hemoglobin within ONE YEAR.

**Student's Name**

_____

**Height_____ Weight _____**

**Hearing Evaluation:** Right _____ Left _____

**Vision Screening:**
Without Glasses/With Glasses (Circle)
Right _____/_____
Left _____/_____

**Temp _____ Pulse _____ Resp _____ B/P _____**

**Urinalysis Results:**

_____

**Hemoglobin Results:**

_____

**TB Test** (required within past year)
Date given _____ Date Read_____ Reading _____ Read By _____
Date of Last Chest X-ray _____ Results _____

**IMMUNIZATION RECORD:** Enter Dates (Please attach copy of documented immunization record)

DPT including last tetanus #1_____ #2 _____ #3 _____ #4 _____ #5 _____

MMR #1_____ #2_____ #3_____ Titre _____ Varicella _____ Titer_____
_____

Hepatitis B #1_____ #2 _____ #3_____ Titre _____ Polio #1_____ #2_____
#3_____

**Current Medications:**

_____
_____
____

**Remarks:** Please describe any special health problem or precaution.

_____
_____
_____
_____
_____

| Normal | EVALUATION | ABNORMAL | Please describe each abnormality |
|---|---|---|---|
| | Head, Face & Scalp | | |
| | Nose and Sinuses | | |
| | Neck | | |
| | Mouth and Throat | | |
| | Ears | | |
| | Eyes | | |
| | Lungs and Chest | | |
| | Breasts | | |
| | Heart | | |
| | Vascular System | | |
| | Abdomen | | |
| | Rectum | | |
| | Endocrine | | |
| | G.U. System | | |
| | Extremities | | |
| | Musculoskeletal | | |
| | Skin | | |
| | Neurological | | |
| | Emotional | | |

**Physician Signature** _____ **Date of Examination**_____

**Name of Physician** (Please Print) _____

**Address**

_____

**Phone**

_____

Mail directly to: Weimar Institute Nursing Program, P.O. Box 486, Weimar, CA. 95736