



STUDENT HEALTH SERVICES

L# _____

Phone: 864-388-8885 • Fax: 864-388-8456 • E-mail: StudentWellness@lander.edu
320 Stanley Avenue, Greenwood, SC 29649

This form must be completed before you will be allowed to register. No information provided will affect admission decisions. The information is strictly for use by Student Health Services and will not be released without your written consent. Lander University will not keep a copy on file. Please keep your copy for future reference.

Name: _____
LAST FIRST MIDDLE

Social Security #: _____ Date of Birth: _____ Birth Gender _____ Marital Status: _____

Address: _____
STREET CITY/TOWN STATE ZIP CODE COUNTRYHome Phone #: _____ Cell Phone #: _____ Date you are entering: _____
MONTH / YEAR

Emergency Contact: _____ Relationship: _____ Contact Number: _____

FAMILY HISTORY	Age	State of Health (Excellent, Good, Fair, Poor)	Occupation	If deceased, at what age	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

PERSONAL HEALTH HISTORY (Please answer all questions. If you answer yes to any of these conditions, provide additional information in space below.)

DO YOU HAVE OR HAVE HAD:	YES	NO		YES	NO		YES	NO		YES	NO	
Scarlet Fever			Anxiety			Head Injury			Chronic Diarrhea			
Measles/German Measles			Depression			Chest Pain/Pressure			Recent Gain/Loss of Weight			
Mumps			Frequent Headaches			Heart Palpitations			Dizziness/Fainting			
Chicken Pox			Recurrent Colds			Heart Murmur			Paralysis			
Malaria			Chronic cough			High or Low blood pressure			Kidney/Bladder Problems			
Gum or Tooth Trouble			Asthma			Rheumatic Fever			Sickle Cell Disease			
Ear, Nose, Throat Trouble			Hay Fever			Injury or Disease of Bones/Joints			Sexually Transmitted Disease			
Surgery: Appendectomy			Tuberculosis			Back Problems			HIV Infection			
Tonsillectomy			Shortness of Breath			Tumor/Cyst			FEMALES ONLY			
Hernia Repair			Allergic Reactions:			Cancer				Pregnancy/Miscarriage		
Other			Medication			Jaundice				Irregular periods		
Diabetes			Food			Stomach/Intestinal Problems			Severe cramps			
Seizures			Other			Gallbladder/Gallstones			Excessive flow			
Insomnia			(Please list specifics below)			Hernia Rupture						

List all medications you are currently taking and reason for: _____

Are you under a physician's care or been treated on a regular basis for any condition? YES NO

If yes, provide name and address: _____

Do you or have you had any emotional or psychological issues? YES NO Are you under a psychiatrist's care? YES NO

If yes, provide name and address: _____

Do you have medical insurance? YES NO If yes, please provide information: _____**PROVIDE ADDITIONAL INFORMATION ON ANY CONDITIONS LISTED ABOVE IN YOUR HEALTH HISTORY**

STUDENT IMMUNIZATION FORM

Name: _____ SS#: _____ L#: _____

Student Signature: _____ Date: _____

By signing this document, I testify all content to be true and accurate.

REQUIRED IMMUNIZATIONS

Please submit a copy of your certificate of immunization **OR** a physician may fill out the following:

1.	<p>MMR (Measles, Mumps Rubella)</p> <p>Two doses required for all students born in 1957 or later.</p> <p>A. Dose 1 given age 12 months or later _____ / _____ / _____ <small>Month Day Year</small></p> <p>B. Dose 2 given at least one month after first dose _____ / _____ / _____ <small>Month Day Year</small></p>	Notes
2.	<p>Tdap (Tetanus, diphtheria and pertussis)</p> <p>One dose received within the last 10 years.</p> <p style="text-align: center;">_____ / _____ / _____ <small>Month Day Year</small></p>	Notes
3.	<p>Meningococcal Vaccine</p> <p>Required for all students age 24 years or younger.</p> <p>Meningococcal-ACWY _____ / _____ / _____ <small>Month Day Year</small></p>	Notes

Signature*: _____ Date: _____

*Healthcare provider signature and/or stamp **REQUIRED**

A declination waiver for the meningococcal vaccination is available upon request for students 25 or older. Medical and religious exemption forms are also available upon request.