LANDER UNIVERSITY

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: _____ Sex: _____ Marital Status: _____

Address: _____
STREET CITY/TOWN STATE ZIP CODE COUNTRY

Home 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					
Other			Medication			Jaundice			Pregnancy/Miscarriage		
Diabetes			Food			Stomach/Intestinal Problems			Irregular periods		
Seizures			Other			Gallbladder/Gallstones			Severe cramps		
Insomnia			(Please list specifics below)			Hernia Rupture			Excessive flow		

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

SEE REVERSE SIDE

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 <u>OR</u> a physician may fill out the following:

		Notes
1.	MMR (Measles, Mumps Rubella) Two doses required for all students born in 1957 or later. A. Dose 1 given age 12 months or later _____ /_____/_____ (Month Day Year) B. Dose 2 given at least one month after first dose _____ /_____/_____ (Month Day Year)	

		Notes
2.	Tdap (Tetanus, diphtheria and pertussis) One dose received within the last 10 years. _____/_____/_____ (Month Day Year)	

		Notes
3.	Meningococcal Vaccine Required for all students age 24 years or younger. A. Menactra _____ /_____/_____ (Month Day Year) -OR- B. Menomune _____ /_____/_____ (Month Day Year)	

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.