Seattle Pacific University — Health Services
STUDENT HEALTH AND IMMUNIZATION FORM

This form must be completed, signed, and uploaded into the patient portal at spu.edu/healthservices or returned directly to Health Services to avoid a registration on your account. **Upload forms through the patient portal or return forms to:**

Seattle Pacific University
3307 Third Avenue West, Suite 110
Seattle, WA 98119-1922
Phone: 206-281-2231 | Fax: 206-281-2674

PART 1 | *To be completed by the student.*

Student ID #: ☐☐☐☐☐☐☐☐☐

Name:_____ **Birth date:** _____
LAST FIRST MIDDLE MONTH / DAY / YEAR

Privacy notice
Health information and privacy are protected by law. I have reviewed the HIPAA and Practice Privacy Notice available on the Health Services website. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting SPU Health Services by phone or in writing.

Immunization registry
I understand that SPU Health Services is contracted with the Washington State Immunization Information Exchange and will access my available immunization records unless requested in writing not to.

Consent for care
I authorize SPU Health Services, including employed, licensed, advanced registered nurse practitioners, and other trained staff to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include services and supplies related to my health and may include (but is not limited to) preventative, diagnostic, therapeutic, rehabilitative, maintenance, palliative care, counseling, assessment, or review of physical or mental status/function of the body and the sale or dispensing of drugs, devices, equipment, or other items required and in accordance with a prescription and or associated fees.

Meningitis information
Washington state law requires that information on meningococcal disease must be provided to each enrolled first-time student. I have read the information on meningitis available on the Health Services website, and I understand the risks for meningococcal disease and how it can be prevented.

I have reviewed the above and completed the Health and Immunization History Form attached. I understand a hold on registration for classes may occur and will not be removed until this form is completed and signed and is submitted to Health Services.

_____ _____ _____
STUDENT NAME (PRINT) STUDENT **SIGNATURE** DATE

_____ _____ _____
PARENT OR GUARDIAN NAME (PRINT) PARENT OR GUARDIAN **SIGNATURE** DATE
(IF STUDENT IS UNDER 18 YEARS OLD)

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PART 2 | *Required by ALL entering SPU students*

Immunization documentation can include one or more of the following:

1. Health care provider signature below to confirm dates entered.

2. Attached copy of official health document (i.e., immunization card, immunization summary from health care providers' office, pharmacy, or state registry document).

3. Attached laboratory results of blood test (rubeola or measles titer) to demonstrate immunity to measles.

All INCOMING STUDENTS:	DATE	DATE	
Measles vaccine (e.g., MMR): At least two doses after 12 months of age or born before 1/1/1957.	1)	2)	Attach official copies of immunization documentation or have health care provider sign below.

Or: Positive rubeola (measles) titer date: 1) _____

INTERNATIONAL STUDENT ONLY:	TEST DATE	RESULTS DATE	RESULTS	
TB Screen (skin or blood test) Must be done within last six months and done in the United States.	Date: _____	Date: _____	Positive Negative *(circle one)*	_____ mm
Bacille calmette guerin (BCG) vaccine	Date: _____			

_____ HEALTH PRACTITIONER NAME (PRINT) *(MD, DO, ARNP, PA)*

_____ HEALTH PRACTITIONER SIGNATURE OR STAMP

_____ DATE

PART 3 | *Additional recommended immunizations and screenings*

We strongly encourage all students to discuss complete immunization recommendations with their primary care provider. College-age students especially, should be up to date on recommended meningitis and tetanus, diphtheria and pertussis (Tdap) vaccines, as well as all other routine immunizations. Please refer to the information on meningitis available on our Health Services website.

	DATE	DATE	DATE
Meningococcal (MCV4) (within last five years)	1)	2)	3)
Meningococcal (Men B)	1)	2)	3)
Tdap (at least one after age 11), **Td** (every 10 years)			
Influenza (recommended annually)	1)	2)	
Varicella	1)	2)	
Polio	Series	Booster	
Hepatitis A	1)	2)	
Hepatitis B	1)	2)	3)

Tuberculosis Risk/Screening
Tuberculosis screening is required for all international students and should also be considered for anyone with increased risk factors.

Review the screening questions below with your health care provider. If you answer yes to any of the following questions a Tuberculosis skin or blood test may be recommended.

- Have you had a new cough for the last three weeks?
- If you have a chronic cough, has it become worse in the last three weeks?
- Have you coughed up blood in the last three weeks?
- Have you lost weight unintentionally in the last two months?
- Have you had fevers in the last three weeks?
- Have you been unusually tired for the last three weeks?

PART 4 | *Medical history*

HISTORY OF ILLNESS
If you have had any illness listed below please enter year diagnosed by a clinician:

Alcoholism_____
Allergies _____
Anemia_____
Anxiety_____
Arthritis_____
Asthma_____
Back/neck injury_____
Bleeding or blood disorder _____
Broken bones _____
Chickenpox/shingles _____
Concussion_____
Depression_____
Diabetes_____
Drug dependency_____
Epilepsy_____
Eye or vision problem_____
Gall bladder trouble_____
Hearing loss_____
Heart murmur_____
Heart condition _____
Hemorrhoids_____
Hepatitis_____
Hernia_____
Hypoglycemia_____
Intestinal trouble_____
Irregular periods_____
Kidney problem/infection_____
Loss of body part/function_____
Lump in breast_____
Lump in testicle _____
Mononucleosis_____
Psychiatric illness_____
Ovarian cyst_____
Paralysis_____
Pneumonia_____
Rheumatic fever_____
Severe menstrual cramps_____
Severe or frequent headaches_____
STI/STDs_____
Thyroid disorder _____
Tumor or cancer_____
Ulcer_____

Other serious illness or injury not listed: _____

If you are currently receiving treatment for any of the problems you have noted above, please give details:
_____
_____
_____

Have you ever had an operation or been hospitalized for any other reason? Yes_____No_____
If yes, please give age and reason. _____

Medications: List current medications and dosages (include daily, as needed and emergency medications, and over the counter medications or supplements):_____
_____
_____
_____

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Allergies

Have you ever had an allergic reaction to a medication? Yes____No_____
Please list the medication and explain type of reaction (e.g., rash, hives, anaphylaxis)

_____

Do you have any environmental or food allergies (including bee stings)? Yes____No_____
Please list and explain type of reaction (e.g., rash, hives, anaphylaxis)

_____

Do you carry medication for anaphylaxis? Yes____No_____
Please list:_____

Family History

Please list any significant family (blood relative) medical history (e.g., heart disease, diabetes, cancer, respiratory conditions):

_____

_____

HEALTH HABITS Your current height: _____ and weight: _____

Do you eat regular meals? Yes _____ No _____

Are you on a special diet? Yes _____ No _____

If so, what type of diet?_____

Do you exercise regularly? Yes _____ No _____

Do you use tobacco — smoke, vape, or chew? Yes _____ No _____ If so, how much? _____

Do you drink alcohol? Yes _____ No _____ If so, how much? _____

Do you use marijuana or other substances? Yes _____ No _____ If so, how much? _____

EMOTIONAL

I often feel sad, guilty, or hopeless about the future. Yes _____ No _____

I have previously been diagnosed with anxiety, depression, eating disorder, or other emotional illness.

Yes _____ No _____

If yes, please give brief description and current treatment plan if needed. _____

_____

_____

_____

Emergency!

Do you have a medical condition that could result in an emergency? Be sure to enter your emergency contact information in Banner (**spu.edu/*banner***). Once there, choose the Personal Menu and then Emergency Contact Information.

If you have questions about this form or any other questions for our Health Services team, contact us or visit us at **spu.edu/healthservices.**

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