



Dear Student;

Congratulations on your admission to Wichita State University. We wish you a successful and healthy college experience.

There have been outbreaks of various vaccine-preventable diseases on college campuses nationwide causing disruption of campus activities. Many students who have contracted these diseases had inadequate evidence of immunity. The Advisory Committee on Immunization Practices for the Centers for Disease Control (CDC) and the American College Health Association recommends all college students receive two doses of Measles, Mumps and Rubella (MMR) and all new incoming freshmen receive a Meningitis vaccine. Universities bring together large concentrations of persons susceptible to these diseases. Students living in residence halls or sorority/fraternity houses are at greater risk of contracting meningococcal bacteria. Many states now require the Meningitis vaccine for all college students.

Based on information from the CDC, the University also recognizes the importance of Polio, Tetanus-diphtheria (Td), Hepatitis B, and Varicella (chicken pox) immunizations.

We **strongly** recommend you have proof of receiving the following:

- a. **Two** doses of MMR vaccine after 12 months of age
- b. Td booster or Tdap vaccine within the past ten years
- c. Oral Polio vaccine series
- d. Three Hepatitis B vaccines
- e. Varicella vaccine series

These are required:

- f. TB screening (required for all newly admitted students.) Click [here](#) for link explaining process.
- g. Meningitis vaccine – (this is **required** if you are a first time resident in any WSU Residence Hall)

We **must** have proof of your immunizations. Please send a **copy**, (**NO originals**) of your immunization record (check with your physician, county health department or high school), along with the [Health History form](#) and [TB Screening form](#) to:

Wichita State University, Student Health Services, 1845 Fairmount, Wichita, KS 67260-0092
Our telephone number is (316) 978-3620 if you have questions.

If you find that your immunizations are not current, please check on availability of these at WSU Student Health Services, 209 Ahlberg Hall. Thank you for taking time to ensure that you have proper immunizations and for providing this information for our records. If we can be of additional service to you during your enrollment at WSU, please let us know.

Sincerely,

Marilyn R. Yourdon, ARNP
Director

James Keller, M.D.
Medical Director



Always Striving to Better Serve "U"

Please attach documentation and mail to:

Student Health Services
Wichita State University
1845 Fairmount
209 Ahlberg Hall
Wichita, KS 67260-0092
(316) 978-3620

IMM
Compliance _____
Noncompliance _____
-for office use only-

CONFIDENTIAL HEALTH HISTORY FORM

Have you previously used WSU Student Health Services?

Date: _____

Yes _____ No _____

Last Name _____ First _____ Middle _____

Wichita Address _____ Wichita Phone _____

My WSU ID# _____ Date of Birth _____ Sex _____ Race _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Business Phone: _____

MEDICAL HISTORY Do you have a present or past history of: (check all that apply)

- Alcohol abuse, Anemia, Arthritis, Asthma, Back problems, Cancer, Chickenpox, Colitis, Convulsions, Cough (chronic), Depression, Diabetes, Disability/handicap*, Drug abuse, Ear trouble/hearing loss, Eating disorder, Eye disease/problems, Gallbladder trouble, Hay fever (recurrent), Head injury, Headache (recurrent), Heart disease/problems, Hepatitis/Jaundice, Hernia/rupture, High blood pressure, Intestinal/Stomach Prob., Joint disease/injury, Measles, red, Menstrual problems, Migraine headaches, Mononeucleosis (Mono), Mumps, Pneumonia, Paralysis, Polio, Psychological counseling, Rheumatic fever, Rubella (3 day measles), Scarlet fever, Seizures, Sexually trans. dis (STD), Sickle Cell Trait/Anemia, Sinus trouble, Skin problems (chronic), Sleep problems, Spleen, surgical removal, Thyroid disease, Tuberculosis, Urinary Tract Infection

Other: _____

*Describe disability/handicap: _____

Do you use tobacco products? (Pipe, cigar, cigarettes or chewing tobacco, etc.) Yes _____ No _____

Stop Date _____

Medications: (list all, including birth control): _____

Drug Allergies: _____

Allergies: (latex, tape, food, others): _____

Hospitalizations/Surgeries: _____

Family History

(place relationship in blank)

Alcohol/Drug Abuse _____

Death before 50 _____

Elevated Cholesterol _____

Hypertension/Stroke _____

Cancer/type _____

Diabetes _____

Heart Disease _____

Mental Illness _____

Other: _____

