# Kansas Wesleyan Emergency Medical Form

**Personal Information:**

Student ID _____ Gender : Male__ Female __ Today's Date _____

_____

Last Name First Name Middle Initial Date of Birth

_____

Permanent Mailing address City/ State/ Zip

(___)_____ (____)_____

Home phone Mobile Phone

**Emergency Contact Information:**

Name: _____ Relationship_____

Address: _____ City/State/ Zip_____

(____)_____ (____)_____ (____)_____

Home Phone Work Phone Mobile Phone

Primary Physician Name _____ Office Phone # (___)_____

**Insurance Information:** Please attach copy of Front and Back of card

Company: _____ Id#_____ Policy #_____

Address _____ Phone(___)_____ Circle Type: HMO PPO

Policy Holder: _____ Date of Birth: _____

_____ **Initial if No Insurance Coverage**

**Medical History:** Do you presently have or have had any of the following medical conditions? (Check all that Apply)

- ☐ Allergies (please List)
- ☐ AID/HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Back Problem
- ☐ Blood disorder
- ☐ Chicken Pox
- ☐ Cancer (_____)
- ☐ Cardiac (Heart) Abnormalities
- ☐ Diabetes
- ☐ Disability/ Handicap
- ☐ Ear Trouble/ Hearing Deficit
- ☐ Eating Disorder
- ☐ Glasses/ Contacts
- ☐ Headaches
- ☐ Head Injury/ Concussion
- ☐ Hepatitis
- ☐ Hernia
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Menstrual Irregularities
- ☐ Mental Health Disorder
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Muscle/ Joint Problems
- ☐ Pneumonia
- ☐ Respiratory Problems (other)
- ☐ Rheumatoid Athritis
- ☐ Seizure Disorders
- ☐ Serious Injuries Skin Disorders
- ☐ Skin Problems
- ☐ Sleep Problems
- ☐ Stomach or Intestinal Problem
- ☐ Thyroid Problems
- ☐ Splenectomy
- ☐ Tuberculosis

**Please Explain any marked boxes from above:**

_____

_____

_____

**Medications Currently Taken:** _____

**Family History:** (Closest Biological Family Members, Please indicate Relationship) _____Initial if You Are Adopted

- ☐ Asthma ____
- ☐ Alcohol Abuse ____
- ☐ Cancer ____
- ☐ Death before 50 ____
- ☐ Diabetes ____
- ☐ Heart Disease ____
- ☐ High Blood Pressure ____
- ☐ High Cholesterol ____
- ☐ Mental Illness ____
- ☐ Stroke/ Blood Clot____

## Immunizations: Please Attach Official Copy of Record

It is important to your personal health, as well as the Kansas Wesleyan Univeristy community health, that your immunizations are complete and up-to-date. The following persons are exempt from needing to show documented evidence of immunizations:

_____ 1. I have a physical condition such that an immunization would endanger life or health.
_____ 2. I adhere to a religion/personal belief whose teachings are opposed to immunizations.

HPV _____
Hepatitis 1____ 2_____ 3_____
MMR (Mumps/Measles/ Rubella) _____
Tetanus (Most Recent Booster)_ _____
Tuberculosis (TB) Skin Test _____ (Most recent)
Vericella (Chicken Pox) _____

## Meningococcal/ Mennigitis (Required) _____

**Or**

**Mennigitis Vaccine Waiver:** to be completed by the individual (or parent/guardian for individuals less than 18 years of age) **requesting an exemption from the requirement.**

**Section 1A: For students 18 years of age or older:**

I am 18 years of age or older. I am aware that meningococcal disease is a rare, but life-threatening illness. I understand that Kansas Wesleyan University policy requires that students residing in the residence halls be vaccinated against meningococcal disease or sign a waiver. I voluntarily agree to release, discharge, indemnify and hold harmless Kansas Wesleyan University, it officers, employees, and agents from any and all costs, liabilities, expenses, claims, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized against meningococcal disease.

Print Name _____

Signature of Student _____ Date _____

**Section 1B: For students under 18 years of age:**

I am the parent/guardian of _____I acknowledge that the disease is rare but life threatening. I understand that Kansas Wesleyan University policy requires that students residing in the residence halls be vaccinated against meningococcal disease. I voluntarily agree to release, discharge, indemnify and hold harmless Kansas Wesleyan University, its officers, employees and agents from any and all costs, liabilities expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to have the above named individual immunized against meningitis.

Print Parent/Gaurdian Name _____

Signature of Parent/Gaurdian _____ Date _____

## Affirmation:

By Signature, I confirm all information on this form to be correct to the best of my knowledge. I also give Kansas Wesleyan University permission to arrange emergency medical care for me if the circumstances arise.

Print Name _____

Signature of Student _____ Date _____

## For Students Under 18 years of age:

I hereby confirm that the information on this form is correct to the best of my knowledge for _____(name of student). I also give Kansas Wesleyan University permission to arrange emergency medical care for the above named student if the circumstances arise.

Print Parent/Gaurdian Name _____

Signature of Parent/Gaurdian _____ Date _____