Rev. 02/07
C-1

UNIVERSITY OF DELAWARE - STUDENT HEALTH SERVICE
LAUREL HALL, NEWARK, DELAWARE 19716-8101
(302) 831-2226 FAX (302) 831-6407

Dear Student:

The staff of the Student Health Service is pleased that you have been offered admission to the University of Delaware. University policy **requires** that all entering undergraduate and graduate students complete the following forms:

- **MENINGOCOCCAL MENINGITIS VACCINATION OR WAIVER FORM**
  State of Delaware legislation (SB# 175, June 27, 2001) requires recording of your response to information on meningococcal meningitis and availability and benefits of vaccination and your decision to be vaccinated or not to receive the vaccine.
- **PERSONAL AND FAMILY MEDICAL HISTORY FORM**
  This form assists the Student Health Service medical staff to provide quality medical care.
- **IMMUNIZATION DOCUMENTATION FORM**
  The University of Delaware requires that all entering student **must** be immunized for measles, mumps and rubella. Students not immunized according to this requirement cannot register at the University of Delaware at the beginning of the next semester.
  All entering students from high risk countries and those entering health care professions must also be screened for tuberculosis with a PPD (Mantoux) Skin Test administered within 6 months prior to beginning classes. (See enclosed Immunization Documentation Form)

Please see the Immunization Record form for information about religious and medical exemptions. Students admitted for the **fall term** should return the forms in **June.** Students admitted for the **spring term** should return the forms in **January.** If you receive the forms after these dates, please complete and return them as soon as possible. If the forms are not completed and returned, **you will not be permitted to register for the next semester.**

If you are presently under the care of a physician for chronic disease or other medical condition(s), ask your physician to forward information pertaining both to your medical problem and its treatment to Student Health Service. This will assist in continuity of your care.

The Student Health Service gives allergy injections at regularly scheduled times. Have your physician provide signed detailed instructions. We require that your physician give the first injection of every new vial. We will store your prescribed extract at the Student Health Service.

Federal law prohibits us from making pre-admission inquiries about disabilities. Information regarding disabilities, voluntarily given, will not affect any admission decision. If you require special services because of a disability, you may call the Academic Enrichment Center (learning disabilities, ADD or ADHD), 302-831-2805 or the ADA Program Coordinator (other disabilities), 302-831-3670.

Sincerely,

E.F. Joseph Siebold, D.O., F.A.A.P.
Director

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* If you will be **under age 18 at the time of enrollment** it is very important that the Student Health Service have permission from either your parent(s) or guardian(s) to provide medical care until your 18th birthday. Please have one or both of them sign the consent form below:

I hereby grant permission to the Student Health Service of the University of Delaware to render medical care to my

dependent____.
(Name of Student)

Name/ Relationship__________________ / __________________	Name/ Relationship__________________ / __________________
Signed____	Signed ____
Date____	Date ____

ALL MEDICAL RECORDS ARE CONFIDENTIAL

*** *THIS INFORMATION MUST BE COMPLETED OR FORM WILL BE RETURNED.* (Please Print or Type)**

* **STUDENT NAME** ____
Last First Middle

* **UD ID#** ______________________________ ☐ FEMALE ☐ MALE

* **DATE OF BIRTH** ______________ PLACE OF BIRTH______________________________

* **NAME OF PARENT, GUARDIAN, OR SPOUSE** ______________________ / __________
Relationship

* **ADDRESS OF PARENT, GUARDIAN, OR SPOUSE** ______________________________
Street City State Zip

* **HOME/WORK TELEPHONE OF PARENT, GUARDIAN, OR SPOUSE** (____)__________ /(___) __________
Area Code (home) Area Code (work)

CELL PHONE (_____) ______________

Names, Addresses and Phone Numbers of TWO persons to be contacted in case of an emergency, and in the event that parent, guardian or spouse cannot be notified!

* 1.______________________________ Telephone (______)________________
Name Area Code

____
Address

(________)______________________________
(Cell Phone)

* 2.______________________________ Telephone (______)________________
Name Area Code

____
Address

(________)______________________________
(Cell Phone)

NAME OF PRIMARY PHYSICIAN ______________________________

ADDRESS OF PRIMARY PHYSICIAN______________________________

______________________________ Telephone (___) ____________
Area Code

PLAN TO ENROLL: ☐ FALL 20_____ ☐ WINTER 20_____ ☐ SPRING 20_____ ☐ SUMMER 20_____

CLASSIFICATION: ☐ FRESHMAN ☐ ASSOCIATE IN ARTS ☐ TRANSFER
☐ RE-ADMIT ☐ GRADUATE ☐ OTHER

* ______________________________ ______________________
STUDENT'S SIGNATURE **Date**

* *THIS INFORMATION MUST BE COMPLETED OR FORM WILL BE RETURNED.*

* **INSURANCE:**

If you do NOT have health insurance check here. ☐

DOES YOUR INSURANCE REQUIRE PREAUTHORIZATION FROM YOUR INSURANCE CARRIER PRIOR TO X-RAYS OR OUTSIDE LABORATORY TESTS BEING ORDERED?

☐ NO ☐ YES If yes, include the telephone number. ______________________

Telephone Number

* ______________________

Responsible party for billing

____

Name

____

Address

STUDENT HEALTH SERVICE USES “LabCorp” FOR OUTSIDE LABORATORY TESTS.
DOES YOUR INSURANCE COMPANY PARTICIPATE WITH THEM?

☐ NO ☐ YES

PLEASE INCLUDE A COPY OF FRONT AND BACK OF YOUR MEDICAL INSURANCE CARD AND PRESCRIPTION INSURANCE CARD.

Include a copy of the front and back of your medical insurance and prescription cards here.

STUDENTS SHOULD ALSO HAVE THEIR OWN PERSONAL COPY OF THESE CARDS.

NAME: LAST	FIRST	MIDDLE	UD ID #:	BIRTH DATE:

* **DRUG ALLERGIES/SENSITIVITIES, LATEX ALLERGY, FOOD ALLERGIES**

- ☐ NONE
- ☐ PENICILLIN, AMPICILLIN
- ☐ LATEX ALLERGY
- ☐ SULFA DRUGS (please specify) ______________________
- ☐ OTHERS (please specify) ______________________
- ☐ FOOD ALLERGIES ______________________

DO YOU SMOKE?

☐ YES ☐ NO

CURRENT MEDICATIONS - taken on a regular basis (i.e., insulin, birth control pills, seizure or heart medicine.)

☐ NONE

DATE STARTED	NAME	DOSAGE

CURRENT (or past) MEDICAL PROBLEM - (i.e., seizures, diabetes, thyroid problems, asthma, heart problems,allergies, etc.)

☐ NONE

DATE STARTED	

HOSPITALIZATIONS AND SURGERIES (please list **ALL**)

☐ NONE

DATE	

FAMILY HISTORY OF ILLNESSES - Please list if there is a family (e.g. grandparents, siblings) history of illness such as diabetes, high blood pressure, sudden/unexplained deaths, etc.:

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