

KETTERING UNIVERSITY WELLNESS CENTER
HEALTH AND MEDICAL HISTORY
1700 West University Ave.
Flint, MI 48504
Office 810-762-9650
Fax 810-762-9929
wellness@kettering.edu

***Required: Must be returned on or before first day of class.**

NOTE: The following information is **confidential** for use of the Wellness Center. It will not be released to anyone without your knowledge or written consent. This form **must** be properly completed and signed before student may receive medical care at the Wellness Center.

Student ID# _____

Name _____
Please Print Last Name (Surname) First Name (Given Name) Middle Name

Address _____
 Street City State or Province Zip Code Country

Telephone Number _____ Birthday _____
 Home or Cell Phone Number Month/day/year Male or Female

Name of Emergency Notification Person

_____ Last Name (Surname) First Name (Given Name) Middle Name

Address _____
 Street City State or Province Zip Code Country

Telephone Number () _____ Email Address: _____
 (Area Code)

Allergies To Medications: _____

Medication Taken Regularly:

1. Asthma, Pneumonia, Bronchitis or Wheezing
2. Stomach/duodenal ulcer Yes No
3. Chicken Pox, Measles or Mumps
4. Do you wear contact or glasses? Yes No
5. Hospitalizations/Surgeries/Chronic Conditions

Immunization History:

- | | Mon | Year |
|-------------------------------------|----------------------------------------|-------|
| * Trivalent Oral Polio (TVOP) | _____ | _____ |
| * Tetanus (within in past 10 years) | _____ | _____ |
| * MMR | _____ | _____ |
| * Hepatitis B series | _____ | _____ |
| | (Recommended but <u>not</u> mandatory) | |

SCREENING TEST: Mandatory, within past 3 years
(Physician signature required)

* TB test Date _____ Year _____ Results _____

Mandatory before entering
If positive: Chest X-Ray is required:

Date: _____

Results: _____

PLEASE FILL OUT AND SIGN BACK OF FORM

Insurance Information: Please enclose a copy of the front/back of insurance card. Please notify the Wellness Center if your insurance coverage changes.

Name of Insurance Company: _____

Policy Holder's Name: _____

Policy Number: _____ Group Number; _____

Family Physician: _____

Last Name	First Name	Middle Name		
Street Address	City	State/Providence	Zip Code	Country
Phone: () _____ Area code				

I hereby give my consent to be treated by the Wellness Center. (Sign in ink)

PARENT OR GUARDIAN

I hereby give my permission for such necessary and Emergency care to be give to my (son/daughter) at an Approved medical facility (to be signed **in ink** by parent or guardian for all applicants under 18 years of age.

Student Signature

Parent or Guardian

Date

Date

STUDENTS: PLEASE SIGN IN INK AND RETURN TO

**Kettering University
Wellness Center
1700 University Ave.
Flint, MI 48504-4898
USA
Office: 810-762-9650
1-800-955-4464 Ext. 9650
Fax: 810-762-9929
Website: wellness@kettering.edu**

