

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# _____

Male _____ Female _____

Name _____
Last First Middle

Birthdate _____
Month Day Year

Address _____
Street City State Zip Code

Cell Phone () _____
Area Code

Name of Emergency Notification Person

Last name First Middle

Address _____

City State Zip Code

Phone: Home or Cell () _____
(Area Code)

Allergies to Medications: _____

Other Allergies: _____

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

6 Medications Taken Regularly:

INSURANCE INFORMATION: MANDATORY

Name of Insurance Company _____

Policy Holders Name: _____

Policy Holders SS#: _____

Group #: _____

* **If possible, please enclose copy of insurance card.**

* Please notify the Wellness Center if your insurance coverage changes.

Immunization History:

Mon Year

* Trivalent Oral Polio (TVOP) _____

* Tetanus (within in past 10 years) _____

* MMR _____

* Hepatitis B series _____
(Recommended but not 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: _____

(MUST HAVE BEFORE ENTERING)

PLEASE SIGN BACK OF FORM

