Taylor University Student Health Record 2024-2025

Explanation and Instructions

All students entering Taylor University are required to submit this completed health record to the Taylor University Health Center **prior** to beginning classes. The health record requires a physical examination completed by a licensed healthcare provider within one year of the first day of **classes**. It is recommended that the physical examination be provided by a healthcare provider who is familiar with the student and his or her medical history.

This health record will be used solely for medical purposes and handled only by professional personnel concerned about your health. The purpose of this health record is:

- To provide information in the event of a medical emergency
- To assist the Health Center by providing information which may not be immediately obtainable from the student
- To indicate conditions for which a student may need care or assistance from the Health Center
- To assist chronically ill or physically challenged persons in making arrangements to facilitate their successful experience at Taylor University

Students/Parents complete all of page two and the top section of page three. Students, along with parents of students under the age of 18, need to sign the bottom of page three. The remainder of page three and all of page four need to be completed by a physician. Please make sure all required sections are completed and signed.

Mail, fax or email completed forms to:

Taylor University Student Development Att: Bev Guffey 1846 Main Street Upland, IN 46989 Fax (765) 998-4840

Phone (765) 998-5379

PLEASE KEEP A COPY OF THESE COMPLETED FORMS FOR YOUR PERSONAL RECORDS

Please make sure this completed health record is received no later than:

August 1 Fall entry Inter-term entry December 15 Spring entry January 15

Taylor University Student Health Record 2024-2025

Welcome to Taylor University. In order to meet many health care needs, Taylor provides a clinic conveniently located adjacent to the Northeast end of campus. Students may receive evaluation and treatment by a nurse practitioner at no charge. Lab services are available on a fee for service basis. We hope we don't get to know you well while you are at Taylor, but we are here if you need us!

Mail or fax completed forms to:

Taylor University Student Development
Att: Bev Guffey
1846 Main Street
Upland, IN 46989
Fax (765) 998-4840
Phone (765) 998-5379

		Phone (765) 998-53	79			
Please have your doctor co	mplete this form a	and retu	rn it to us <i>p</i>	orior to the first day of o	classes.		
NAME: Last (Print)	First	MI S	ex	Date of Birth			
HOME ADDRESS:	City		State	Zip			
Telephone Numbers:	Home		Cell	Campus			
Father's Name	Daytime _I	Daytime phone		Father's Date of Birth			
Mother's Name	Daytime _I	Daytime phone		Mother's Date of Birth			
Guardian's Name	Daytime _l	ohone					
Please enclose a photocopy *Note: If this information is will be sent directly to the	s not provided, ar	ny bill fo	r services t	hat would normally be			
Medical History (If you have a special health navailable accommodations.) Have you had any of the follow	ving?	e you to	contact the	health center prior to you			>
Difficulty sleeping	Yes** No		Heart	problems	Yes**	No	

	Yes**	No
Difficulty sleeping		
Eating issues		
Depression		
Diabetes		
Asthma		
Hypertension		

	Yes**	No
Heart problems		
Surgery		
Seizures		
Broken bones		
Hospitalization		
Tuberculosis		

^{**} Please explain any "yes" answers:

Date

use. Include nutritional supplements, vitamins and over-	the-counter medications.
Are you allergic to any medications? If yes, please list metc.)	nedication and nature of reaction (i.e. rash, trouble breathing
Do you have any impairments or require the use of any a	assistive devices?
Required Immunizations: (You must fulfill these requirements prior to the first day of classes)	Recommended Immunizations: Hepatitis B dose 1// dose 2//
1) MMR vaccination vaccine 1/(At least 28 days apart month day year after 12 months of age)	dose 3/
vaccine 2/ month day year 2) Td/	dose 2
month day year Tdap/	Varicella dose 1/ dose 2// Date of Disease//
month day year (within the last 10 years)	Other Immunizations: Polio (Last dose)//
Tuberculosis screening:	month day year
Is the student a member of a high risk group, lived outside of the United States in the last 5 years, or entering the health professions? If yes, please complete a TB skin test within the past year:	Hepatitis A dose 1/
Date Given:/	Typhoid Oral dose/ or Injection dose/
Results: mm of induration	Yellow Fever/
Positive Negative (If positive please document evaluation and recommendations) Consent for Treatment:	

I have reviewed the above information and believe it to be accurate. I, the undersigned, authorize and consent to treatment. I understand that I may withdraw my consent at any time. Should I be under eighteen years of age, my parent's (or guardian's) signature below indicates approval and consent for medical treatment at the Student Health

Parent or Guardian Signature

Center.

Student Signature

Do you take any medications on a regular basis? If yes, please list the name, dose, strength and instructions for

Name

Physical Examination			Name		
HeightBlood Pres	ssure_	/			
Vision: Uncorrected RightLeft _		Corrected:	RightLeft		
Are there any abnormalities of the follow	ving sy	stems?			
Answer yes or no by check mark ($$)	Yes	No F	Please explain any "yes" answers:		
Head					
Eyes (other than acuity)					
Ears					
Nose					
Throat					
Lungs					
Heart					
Abdomen		<u> </u>			
Genitourinary		<u> </u>			
Hernia		 			
Musculoskeletal					
Metabolic/Endocrine		 			
Neurological Parabitation		 			
Psychiatric Is there loss of seriously impaired		 			
function of any paired organ?					
Is the patient currently being treated for:		 			
Serious medical condition?					
Serious emotional condition?					
Do you have any recommendations					
regarding the care of this student?					
Are you the student's regular physician?					
Recommendations for physical activity: UnlimitedLimited(If limited explain:) (Physical education, intramurals, and varsity sports) Is there a medical contraindication to immunizations: NoYes If yes, please explain)					
Date of Exam:	Ph	ysician Signa	iture:		
Print Physician Name:	Name: Physician telephone number:				
Physician Address:					
Please return completed form to:					
Taylor University Student Development Att: Bev Guffey					

Taylor University Student Development Att: Bev Guffey 1846 Main Street Upland, IN 46989 Fax (765) 998-4840 Phone (765) 998-5379