

Student Health Service

Student Health Form 2017–2018

Please Note: All students must complete and return this form to the Student Health Service prior to your arrival on campus. Deadline for return is June 1 for students beginning study in the fall and January 1 for those beginning in January. All information disclosed on this form will be kept confidential and will be shared only on a need-to-know basis.

The following information must be completed by the student and/or a parent or guardian:

First Name Middle Name Last Name

Lesley Student ID# On-campus housing Commuting

Date of Birth Gender

Home Phone Cell Phone

Home Address

City State Zip Code

Email Address

Date Entering LU Expected Graduation Date

If transfer, college(s) attended Dates Attended

Please check one:

- College of Liberal Arts and Sciences College of Art and Design
 Threshold

Emergency Contact Information:

Name Relationship to Student

Day Phone Evening Phone

Cell Phone

Name Relationship to Student

Day Phone Evening Phone

Cell Phone

Consent for Treatment

I give permission for medical and mental health treatment for my child/student if they seek treatment while they are a student at Lesley University. This includes, but is not limited to, referral to a local hospital, hospitalization, anesthesia and/or surgery, should it be necessary. This also includes sharing of information provided by Lesley University Counseling Center staff when needed as part of your integrated medical treatment.

Parent/Guardian Signature Date

Print Name Relationship

Student Signature Date

IMPORTANT NOTE: Attach a copy of the front and back of your health insurance card.

Please indicate your health insurance coverage information:

- Lesley University Health Insurance OR Other

If you checked other, please provide the insurance information:

Name of Insurance Company

Address

ID# Group #

Name of Subscriber

Attention HMO/PPO/IPA Subscribers:

If pre-authorization is required for laboratory tests, x-rays, referrals, hospitalization, etc. include necessary contact information.

Name of Contact Phone

For Student Health Service use only:

- Immunizations complete: _____
 Immunizations needed:
 MMR #1 MMR #2 Tdap
 Hepatitis B #1 Hepatitis B #2 Hepatitis B #3
 Meningococcal vaccine/waiver Varicella #1 Varicella #2

Date Notified: _____

Student Health Service

Student Health Form 2017–2018 (continued)

Family History

	Age	State of Health	Age of Death	Cause of Death
Parent				
Parent				
Siblings				

Have any of your immediate relatives had any of the following:

Alcoholism No Yes Relationship: _____
Cancer No Yes Relationship: _____
Diabetes No Yes Relationship: _____
Heart Disease No Yes Relationship: _____

High Blood Pressure No Yes Relationship: _____
Mental Illness No Yes Relationship: _____
Tuberculosis No Yes Relationship: _____

Personal History

Do you have now or have you ever had (circle all that apply):

- | | | | |
|--|--|---|---|
| <input type="radio"/> Acne | <input type="radio"/> Chickenpox | <input type="radio"/> Impaired mobility/paralysis | <input type="radio"/> Seizure disorder |
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Colitis/Ileitis | <input type="radio"/> Kidney stone | <input type="radio"/> Sickle cell disease |
| <input type="radio"/> Anemia | <input type="radio"/> Deaf/hearing impairment | <input type="radio"/> Kidney disease | <input type="radio"/> Thyroid disease |
| <input type="radio"/> Anorexia Nervosa/Bulimia | <input type="radio"/> Depression | <input type="radio"/> Learning disability | <input type="radio"/> Tonsillectomy |
| <input type="radio"/> Anxiety/OCD | <input type="radio"/> Diabetes | <input type="radio"/> Malaria | <input type="radio"/> TB/tuberculosis |
| <input type="radio"/> Appendectomy | <input type="radio"/> Emotional/mental illness | <input type="radio"/> Migraines/chronic headaches | <input type="radio"/> Ulcer/stomach problems |
| <input type="radio"/> Arthritis | <input type="radio"/> Heart disease/problem | <input type="radio"/> Mononucleosis | <input type="radio"/> UTIs (frequent/recurrent) |
| <input type="radio"/> Asthma | <input type="radio"/> Hepatitis (Type _____) | <input type="radio"/> Neuromuscular disease | <input type="radio"/> Other: _____ |
| <input type="radio"/> Autism/Asperger | <input type="radio"/> High Blood Pressure | <input type="radio"/> Phlebitis/deep vein clot | |
| <input type="radio"/> Blind/visual impairment | <input type="radio"/> High Cholesterol | <input type="radio"/> Pneumothorax | |
| <input type="radio"/> Cancer/Malignancy | <input type="radio"/> HIV infection/disease | <input type="radio"/> Positive TB test | |

Please explain all that applied to you and any other significant medical conditions (with dates):

Hospitalizations (Please provide details, including dates, diagnosis, surgeries, etc.):

Medications:

Allergies to Medications:

Type of Reaction:

Allergies to other things:

Type of Reaction:

ADDITIONAL CONTACT INFORMATION

For physical, sensory, chronic medical and psychiatric conditions contact:

Ruth Bork
Director of Access Services for Students with Disabilities
617.349.8194 • TTY 617.349.8544 • rbork@lesley.edu

For learning disabilities, attention disorders, and spectrum disorders/Asperger contact:

Kimberly J. Johnson
Director of LD/ADD Academic Support Program
617.349.8462 • kjohnso7@leslet.edu