Welcome to Lawrence University!

The Wellness Services team is here to provide student-centered, high-quality care that promotes lifelong wellness and supports academic success. Please take time to check our website for more details. https://www.lawrence.edu/students/wellness

Prior to arriving on campus, be sure to complete the entire checklist below. Submit your paperwork in PDF or JPEG form via LEAPFILE to Wellness Services by **Deadline: August 1st**, or student's course registration will be held.

LEAPFILE®
Simple and Secure file delivery!

New Student Health Services Checklist: Due by August 1st:

- ☐ **Part I: Student Information and Emergency Contacts**
- ☐ **Medical Consent for Treatment of Minors** (if student is under 18 when form is completed)
- ☐ **Health insurance information** – *Ensure coverage in Appleton*
- ☐ **Part II: Medical History**
- ☐ **Part** III: **Immunization Record**
- ☐ **Part V: Hepatitis B and Meningococcal Meningitis Immunization Health History**
- ☐ **Part VI: Physical Exam**

  Athletes need athletic physical form completed – see website
  Physical should be done less than 1 year prior to the start of classes

***Email questions to wellnessservices@lawrence.edu or call 920-832-6574.**

Prescription Information:

Students are encouraged to have a plan for prescription refills during the academic calendar and may need to schedule appointments with home providers over breaks. Prescriptions can be sent to Hometown Pharmacy and will be delivered to Wellness Services. Check the Health Center's website for more information or contact Wellness Services with questions.

VARSITY ATHLETES MUST COMPLETE

☐ List your Varsity Sport_____

☐ Submit physical exam records via Athletic Trainer System (ATS)
*Physical completed no more than 6 months prior to season

☐ Submit Health Services Checklist below via LEAPFILE **AND** ATS

ATS®

*Instructions to upload in ATS can be found on the Athletics website.

*Email athletic questions to nevada.j.watson@lawrence.edu or call 920-832-7270.

PART I: STUDENT INFORMATION:

Last name _____ First name_____ MI_____ Preferred name _____

Date of Birth ___/___/____ Sex assigned at birth____ Gender Identity____ Preferred pronoun_____

Home Address_____ City_____ State____ Zip Code_____

Country_____ Home phone_____ Cell phone_____

LU ID_____ Class: Fr So Jr Sr Date completed___/___/____

EMERGENCY CONTACT: (please include at least 2 phone numbers)

1. Name_____ Relationship_____

   Home Address_____

   Home phone_____ Cell phone_____ Work phone_____

2. Name_____ Relationship_____

   Home Address_____

   Home phone_____ Cell phone_____ Work phone_____

CONFIDENTIALITY STATEMENT

All information on these pages is considered confidential and protected. Health Services will not release medical information to anyone including parents unless the student signs a separate release of information specific to each illness/incident. Release of Information forms can be found on the Health Center's website.

STANDING CONSENT FOR ROUTINE TREATMENT OF MINORS: *(for students under 18 years old)*

I, the undersigned parent/guardian of the above named student, hereby give my consent for the provision of routine health care to the said child by health care providers and staff of Lawrence University Health and Counseling Services. This care may be routine diagnostic procedures, examinations, medical treatment, routine laboratory tests, x-rays, health and wellness counseling, and the administration of over-the-counter or prescribed medication. This consent shall be valid for the period of time commencing on the date of the student arrival on campus until the student's 18th birthday. I do hereby indemnify and hold harmless the health care providers and entities and other persons who act in reliance upon this consent. I also authorize treatment by a physician at a local medical facility in the event of an emergency.

Signature of Parent/Guardian_____**Date**___/___/____

Student Name _____ **DOB** _____

HEALTH INSURANCE

All students are required to have health insurance and carry their insurance card with them at all times. CHECK WITH YOUR INSURANCE COMPANY REGARDING COVERAGE IN THE APPLETON AREA. Lawrence offers an accident and sickness insurance plan with coverage in Appleton administered by a servicing agent. For policy information and enrollment procedure click here to be directed to their website.

CHECK WITH YOUR INSURANCE COMPANY REGARDING COVERAGE IN THE APPLETON AREA

The Health Center can assist with minor illness and injury, and will coordinate referrals to local healthcare clinics. Health Insurance would significantly reduce financial responsibility when requiring care in a local clinic or lab work.

Policy Holder's Name_____ Policy Holder Date of Birth___/___/____

Policy Holder's Employer_____

Policy Holder's Address_____

City_____ Sate_____ ZIP_____ Phone _____

Attach picture of the FRONT of insurance card

Attach picture of the BACK of insurance card

INTERNATIONAL STUDENTS CHECK ISS INSURANCE REQUIREMENTS. YOU DO NOT NEED TO COMPLETE THIS PAGE.

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PART II: STUDENT NAME_____ **DOB**_____

Student's Personal Medical History – **Provide date and explanation for any 'YES' answers below**

Have you ever had…	Y	N	DATE	EXPLANATION
Migraines or Frequent/Severe Headaches				
Seizures				
***Cancer or other immunocompromised disorder**				
Eye Disease				
***Diabetes** or other Endocrine disorder (thyroid)				
Mononucleosis				
Rheumatic Fever				
Anemia				
***Sickle Cell Disease**				
Hemophilia				
***AIDS/HIV**				
***Asthma**				
Seasonal Allergies				
Tuberculosis				
***Heart Disease**				
***High Blood Pressure**				
Heart Murmur				
Gastrointestinal Disease				
Hernia				
***Kidney Disease**				
Urinary Tract Infection				
***Hepatitis or other Liver Disease**				
Menstrual Irregularities				
Sexually Transmitted Disease				
Genetic Disorder				
Skin Infection (fungal, bacterial, viral)				
Anxiety				
Depression				
Eating Disorder				
Other Mental Health Disorder				
Physical Disability				
***Obesity**				
Back Injury or Pain				
Joint Injury/Disease				
Broken/Fractured Bones				
Dislocated/Subluxed Joints				
Problems with pain/swelling				
# of Concussions without losing consciousness				
# of Concussions with loss of consciousness				
Surgery				
Positive COVID 19 diagnosis with date				
Any other Condition/Illness:				

***People of all ages with underlying medical conditions, particularly if not well controlled are at higher risk of complications from COVID-19.**

STUDENT NAME_____ **DOB**_____

MEDICATIONS:

NAME OF MEDICATION	REASON FOR MEDICATION

ALLERGIES: List allergy and reaction.

ALLERGEN	REACTION

Family Medical History (parent, grandparent, sibling)

Do any of your immediate relatives have or had...	Y	N	Relationship		Y	N	Relationship
Cancer				Asthma/Seasonal Allergies			
High Blood Pressure				Seizure Disorder			
Sickle Cell Trait				Mental Health Disease			
Tuberculosis				Substance Abuse			
Diabetes				Sudden Death (before 50)			
Heart Disease				COVID-19			
Kidney Disease				Other			

If you are or become a varsity athlete, you also understand and agree that the Lawrence University Athletics Department will have access to this information.

I hereby certify that, to the best of knowledge, the information provided on this form is complete and correct.

Student Signature_____**Date**_____

Parent/Guardian Signature if <18_____**Date**_____

PART III: STUDENT NAME_____ **DOB**_____

IMMUNIZATION RECORD

Students are required to provide immunization records or proof of immunity by copy of lab results or physician signature with diagnosis. **Immunizations should be completed before coming to campus**. Most vaccines are available at the Health Center if unable to complete before arriving. The cost of the vaccine will be charged to the student's account. **Influenza vaccines will be required and will be available on campus.**

Please attach a hard copy of your immunization record

REQUIRED VACCINES	1st DOSE DATE	2nd DOSE DATE	3rd DOSE DATE	History of Disease/ Lab confirmation of immunity
Measles *(2 doses or history of disease)*				
Mumps *(2 doses or history of disease)*				
Rubella *(2 doses or lab report showing immunity)*				
Td or Tdap *(within last 10 years)*				
Hepatitis B *(3 doses if <18yo, 2 doses if 18yo))*				
COVID-19 ***(include original dose and booster dose)***				

***Students who have not been immunized may be excluded from class and residence halls if an outbreak of a vaccine preventable disease occurs on campus.**

OPTIONAL VACCINES	1st DOSE	2nd DOSE	3rd DOSE
Meningitis ***HIGHLY RECOMMENDED*** *(2 doses)*			
Meningitis B ***HIGHLY RECOMMENDED*** *(2 or 3 doses)* *Circle Bexsero or Trumenba*			
Polio			
Hepatitis A *(2 doses)*			
Varicella *(2 doses or history of chickenpox)*			
Human Papillomavirus HPV *(2 or 3 doses)*			
Typhoid			
BCG *(if not born in USA)*			
Other			

Statement of Exemption to Immunization: If you cannot complete the required vaccines, a waiver form must be returned to Wellness Services. Note that students who have not been immunized may be excluded from class and residence halls if an outbreak of a vaccine preventable disease occurs on campus.

Part V: Hepatitis B and Meningococcal Meningitis Immunization Health History Form

Completion of this form is required by the state of Wisconsin annually for all students who live in university housing.

Name _____ _____ _____
Last First MI

LU ID_____ Date of Birth _____

Wisconsin State Statue 36.25(46) requires that all students who will be residing in a campus residence hall receive yearly information regarding the risks associated with Hepatitis B and Meningococcal disease and the effectiveness of the vaccines available to prevent these diseases. The student who resides in campus housing must affirm whether he or she has received vaccinations against Meningococcal disease and/or Hepatitis B, and must provide the dates of the vaccinations, if any. The parents of minor students must provide this information.

Lawrence University requires that the Hepatitis B vaccine be initiated as a condition for enrollment. Immunization for Meningitis is strongly encouraged. Both vaccines are available on campus at the Landis Health Center, but it is recommended that you receive them prior to coming to campus.

A. **Hepatitis B (HBV) Immunization**

Hepatitis B is a potentially life-threatening liver infection caused by a virus that attacks the liver. Hepatitis B virus (HBV) can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. HBV is spread by contact with blood or other body fluids. Many people will have no symptoms when they develop the disease. The primary risk factors for Hepatitis B are sexual activity and injecting drug use. Hepatitis B is completely preventable. A series of 3 doses of the vaccine is available to all age groups and required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases. Hepatitis B vaccine is very effective for preventing Hepatitis B virus infection. After receiving all three doses, the vaccine provides greater than 90% protection.

For more information regarding Hepatitis B, consult the Center for Disease Control Website.

https://www.cdc.gov/hepatitis/hbv/bfaq.htm

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.pdf

☐ I hereby certify that I have read this information and I have received one or all doses of the Hepatitis B vaccine.

Dates of Immunization #1 _____ #2_____ #3_____

☐ I hereby certify that I have read this information and understand that Lawrence requires all 3 doses of the Hepatitis B vaccine. I have elected NOT to receive the Hepatitis B vaccine, and will sign the below waiver.

B. **Meningococcal Meningitis**

Meningitis is inflammation of the protective membranes surrounding the brain or spinal cord, and is usually caused from an infection. Meningitis is most often caused by bacteria or a virus. Bacterial meningitis can be extremely dangerous. Symptoms can come on suddenly and progress quickly. 10-15% of cases result in death. 1 in 5 people that survive will then live with permanent disabilities such as brain damage, hearing loss, kidney damage, or limb amputation. College students are at a higher risk of contracting meningitis because of the close living quarters. Meningitis is spread by oral and nasal respiratory secretions during close contact like kissing or coughing on someone. Meningitis bacteria cannot live outside of the body for very long so is not spread as easily as a cold virus. To prevent contracting Meningitis you should receive the recommended vaccines, wash your hands, and cover your cough. There are 2 different types of the Meningitis vaccine and you need both to ensure the most protection. No vaccine can guarantee 100% effectiveness, but can significantly reduce your risk of illness. The first meningitis vaccine protects against serogroups A, C, W, and Y. The other protects against serogroup B. Depending on the brand, you may need 2 or 3 doses to be fully vaccinated. The immunizations are available at the Health Center. Contact the Health Center for more details. Meningitis symptoms are similar to those of the flu, come on suddenly, and may become deadly fast. Treatment should be provided early with antibiotics. People who are in close contact with the infected person should also be treated as a precautionary measure.

For more information regarding meningitis, consult Center for Disease Control websites.

www.cdc.gov/meningococcal/about/index.html

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.pdf

https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening-serogroup.pdf

☐ I hereby certify that I have read this information and I have received the vaccine for Meningococcal Meningitis.

Dates of Immunization: Meningitis ACYW (Menactra®, Menveo®, and MenHibrix®)

#1 _____ #2_____

Meningitis B (Bexsero® or Trumenba®)

#1 _____ #2_____ #3_____

☐ I hereby certify that I have read this information and I have elected NOT to receive the vaccine for Meningococcal Meningitis.

Signature of student _____ **Date** _____

Parent/Guardian (if student is under age 18) _____ **Date** _____

THIS SECTION IS TO BE FILLED OUT BY A HEALTHCARE PROVIDER ONLY. **ATHLETES NEED ATHLETIC PHYSICAL FORM COMPLETED **

Part VI: Physical Examination

Name _____ **Date of Birth** _____ **Date of Exam** _____

Height _____ inches **Weight**_____ pounds **Temperature** _____ **Pulse** _____ **Blood Pressure** _____

Vision: R 20/_____ L 20/_____ **Corrected: Y N Pupils:** □ equal □ unequal **Hearing:** R ____ L ____

MEDICAL	NORMAL	ABNORMAL FINDINGS	INITIALS
Appearance			
Eyes/Ears/Nose/Throat			
Lymph Nodes			
Heart			
Pulses			
Lungs			
Abdomen			
Skin			
Neurological			
Genitalia/Pelvic (optional)			
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**	**INITIALS**
Neck			
Back			
Shoulder/ Arm			
Elbow/Forearm			
Wrist/Hand			
Hip/Thigh			
Knee			
Leg/Ankle			
Foot			

Tuberculosis (TB) Risk Assessment ****ALL INTERNATIONAL STUDENTS ARE REQUIRED TO BE TESTED****

1. Does the student have signs or symptoms of active tuberculosis disease? □ Yes □ No

If YES, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

If NO, do you feel a tuberculin skin test is needed? □ Yes □ No

2. Tuberculin Skin Test (TST) *International students complete either step 2, 3, or 4*

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be bases on mm of induration as well as risk factors.

Date given: ____/____/_____ **Date read: ____/____/_____**

Results: _____ mm of induration ****Interpretation:** □ negative □ positive

OVER→

STUDENT NAME_____ **DOB**_____

Tuberculosis (TB) Risk Assessment (continued)

3. Interferon Gamma Release Assay (IGRA)

Date obtained: ____/____/_____ **Specify method:** □ QFT-G □ QFT-GIT □ Other

Result: □ negative □ positive □ intermediate

4. Chest X-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/_____ **Result:** □ normal □ abnormal

CLEARANCE

☐ Clearance

☐ Cleared after completing evaluation/rehabilitation for: _____

_____

☐ Not cleared for: _____

Reason: _____

Recommendation: _____

_____

This is to certify that, in my opinion, the above named student is in good health unless if noted above, and is able to participate fully in academic work, physical education programs, and intercollegiate athletics.

Healthcare provider's signature_____ Date _____

Healthcare provider's name (print/type) _____

Address _____ Phone _____