Student Health Service

Student Health Form 2018–2019

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 2018–2019 (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):

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

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