OKLAHOMA WESLEYAN UNIVERSITY STUDENT HEALTH SERVICES!

The university provides a Registered Nurse who assists with the routine medical needs of the campus community. Hours may be posted on the door of the Student Health Services Office, which is in the mansion.

A limited amount of first aid supplies are available in the Student Health Office. Any student who is on prescription drugs, medications, or under a physician’s immediate care should register with the nurse. Local physicians act as consultants and referral sources for those who need special attention.

There are a few items I will need from you to keep on file in the Student Health Office. **Before you register for classes please have the following medical records.**

**MEDICAL FORMS**

The student fills this form out **completely,** signs and dates it. If any student wishes to use the OKWU student health services, a medical form must be completed before enrollment. All traditional students whether living on campus or off campus must have a medical form **completely** filled out and signed by the student.

**COLLEGE ENTRANCE PHYSICAL EXAMS**

This exam is done the summer before the student begins school and is filled out and signed by the physician who performed the exam. All traditional students whether living on or off campus must have a college entrance physical exam. This exam qualifies for an athlete’s athletic physical for their intended sport for this first year.

**IMMUNIZATION RECORD**

Hundreds of people living together in close-quartered conditions can be breeding grounds for illness and diseases. These conditions can be found in many colleges and universities, and so most states require a number of immunizations for all students to be allowed to live and study on campus. Oklahoma Wesleyan University requires all college students to provide proof of meningitis, hepatitis B and measles, mumps, rubella immunizations. You can get a shot record at the student’s physician’s office. Sometimes they are with High School transcripts. The nurse must have a record of the student’s immunizations. This is required by law. If there is any reason that the student has not had these immunizations and does not want to receive them, there must be a signed waiver form on file in the Student Health Office.

Well that is about it. I look forward to meeting you. Have a great year and God bless!

“Nurse Deb”
Debra J. Cook, M.S.N., R.N.
Director of Student Health Services
Oklahoma Wesleyan University
2201 Silver Lake Road
Bartlesville, OK 74006

# 918-335-6264 (office)
# 918-914-9808 (mobile)

*OKWU only discloses personally identifiable information from a Student Health Department record to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals*

Updated March 2017
Oklahoma Wesleyan University Medical Form

Important: This information is strictly confidential and is requested in order that the student may be provided with the best possible medical care. If a student wishes to use the OWU health services and take advantage of the insurance program, a medical form must be completed before enrollment. If a student fails to complete a medical form s/he will be prevented from participating in campus activities such as intramurals, intercollegiate competition, official school representation, etc. Return completed form to Oklahoma Wesleyan University, 2201 Silver Lake Road, Bartlesville, OK. 74006.

Name: _______________________________ Address: _______________________________ Date of Birth: _______________________________
Male Female Social Security Number: _______________ Religion: ___________________________ Phone Number: _______________

In Case of an Emergency, Notify Responsible Party:
Name: _______________________________ Address: _______________________________ Phone Number: _______________
Medical Insurance Company: ________________________ Relationship to Student: _______________ Employer: _______________________
Insurance Company Phone Number: _______________ Policy Number: _______________

Please enclose a copy of health insurance card.

Indicate those that may apply to you: Medicare Deductible Native American Benefits

Medical History

To be completed by student. Please ☑ below if you have had or are currently under treatment for any of the following. (Please explain all ☑s in section below)

☐ Chicken Pox/Measles ☐ High Cholesterol ☐ Vision Problems/Hearing Loss
☐ German Measles (Rubella) ☐ Musculoskeletal Disorders ☐ Thyroid Problems
☐ Mumps/Scarlet Fever ☐ Neurological Disorder ☐ Inflammatory Bowel Syndrome
☐ Rheumatic Fever/Malaria ☐ Epilepsy ☐ Pancreatitis/Gall Bladder Problems
☐ Infectious Mononucleosis ☐ Hepatitis A, B, or C ☐ Reflux
☐ Anemia ☐ Eating Disorder ☐ Rectal Bleeding
☐ Thyroid Disorder ☐ Drug/Alcohol Dependency/Abuse ☐ Hemia/Ulcer
☐ Diabetes Mellitus ☐ Panic/Anxiety Disorder ☐ Recurrent Bladder Infection
☐ Cancer / Tumor / Cyst ☐ Bipolar Disorder ☐ Bleeding / Blood Disorder
☐ Asthma ☐ Mood Disorder/Depression ☐ Kidney Infection
☐ Exercise – Induced Asthma ☐ Obsessive Compulsive Disorder ☐ Chronic Kidney Disease
☐ Shortness of Breath with exercise ☐ Nervousness/Trouble Sleeping ☐ Pelvic / Vaginal Infections
☐ Pneumonia/Tuberculosis ☐ Hospitalized for Emotional Disorder ☐ Testicular Lump
☐ Recurrent Bronchitis ☐ Joint Injury/Bone Fractures ☐ Irregular or painful periods
☐ Recurrent Ear Infection ☐ Head Injury with loss of consciousness ☐ Surgeries
☐ Frequent Colds ☐ Concussion ☐ Chronic rash/Eczema/Hives
☐ Congenital Condition ☐ Fainting/Dizziness ☐ Heat Related Illness
☐ Rheumatic Heart Disease ☐ Seizure Disorder ☐ Serious Accident / Injury
☐ High Blood Pressure ☐ Recurrent Sinusitis or nosebleeds ☐ Migraine or recurrent headaches
☐ Heart Palpitations/Murmur ☐ Recurrent Sinusitis or nosebleeds ☐ Syncope or Fainting with exercise
☐ Chest pain or pressure ☐ Other Conditions: ____________________________

Explanation for any positive answers above: ____________________________

Drug/Medication Allergies (write NONE if none): ____________________________

Other Allergies (write NONE if none): ____________________________

Routine Medications Taken/Purpose: ____________________________

Student Signature: ____________________________ Date: ____________________________

*OKWU only discloses personally identifiable information from a Student Health Department record to appropriate parties in connection with an emergency if knowledge of the information is necessary to protect the health or safety of the student or other individuals.

Updated March 2017
Oklahoma Wesleyan University Physical Examination
To be completed by Healthcare Provider

Name: ___________________________________________ DOB: ______ Sex: _______

Blood Pressure: ___________________ Pulse: _______ Height: _____________ Weight:_________

Visual Acuity:
OD __________ OS __________ OU __________ Hearing:________________________________________

Suggested Laboratory Tests:
Urinalysis: _____Within Normal Limits ____Abnormal if abnormal, explain:__________________________

Hemoglobin: _____Within Normal Limits ____Abnormal if abnormal, explain________________________

<table>
<thead>
<tr>
<th>CLINICAL EVALUATION</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Ears, Nose, Throat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mouth, Teeth, Gums, Tonsils</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Neck and Thyroid</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Lungs / Chest</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Skin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Heart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Genitalia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Extremities / Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Neurological Motion Condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Emotional / Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Feet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Other Findings</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Loss of Paired organ function: ____ No ____Yes if yes, please explain: ______________________________

Recommendation for physical activities, including participation in club, ______Unlimited ______Limited If limited, please explain: ______________________________
intramural & intercollegiate sports:

Signature of Healthcare Provider __________________________ Date ____________
Print name of Healthcare Provider __________________________
Address __________________________________________ Telephone ________ Fax ______

Updated March 2017
# Oklahoma Wesleyan University Record of Immunizations/Testing

**A copy of your immunization record is preferred.**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
<th>Date 1</th>
<th>Date 2</th>
<th>Date 3</th>
<th>Date 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong> (Required by OK law)</td>
<td>Birth-2 months  1-4 months  6-18 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DTaP</strong></td>
<td>5 doses unless 4th dose is after age 4, or for grades 6-12 3 doses</td>
<td>2 months  4 months  6 months  4-6 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DPT/HIB</strong> (Diphtheria-Tetanus acellular-Pertussis/H. influenzae)</td>
<td>15 months must be fourth dose of DTaP &amp; HIB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>HIB</strong> Haemophilus influenzae Type b3</td>
<td>2 months  4 months  6 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IVP</strong> Inactivated Poliovirus vaccine</td>
<td>2 months  4 months  15-18 months 4-6 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MMR</strong> (Required by OK law) 2 doses-first dose after first birthday</td>
<td>12-15 months  4-6 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Varicella</strong> (Chickenpox)</td>
<td>Must be at least 12 months of age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PCV-7</strong> (Pneumococcal Conjugate vaccine) Not required by state but highly recommended and given by state</td>
<td>2 months  4 months  6 months  12-15 months</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A</strong> Must be at least 2 years old  6-8 months between 1st &amp; 2nd doses</td>
<td>First year on-campus college students have increased risk of contracting meningococcal meningitis. The ACIP (Advisory Committee on Immunization Practices) recommends that college students be made aware of this disease and given the opportunity to become vaccinated.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Meningococcal Meningitis**

Date:

A TB Skin Test is recommended  

Date of test:  

Results:

**TB Skin Test is mandatory for International Students**
INSTRUCTIONS: Complete this form only if student is a legal minor (less than 18 years of age) or less than 21 years of age and will be traveling to other states with the university for any reason as of the first day of orientation week. NOTE: Form must be notarized.

The undersigned, having legal guardianship of __________________________
does hereby authorize and direct a doctor in a clinic or emergency room (or physician assistant working with him/her) to provide diagnosis and treatment as their judgment indicates to said minor while said minor is enrolled as a student at Oklahoma Wesleyan University in Bartlesville, OK.

It is OWU’s policy that each student must have health insurance coverage. OWU carries a minimal accident insurance policy on all full-time students. This policy is a supplemental coverage, which pays only after other collectable group or individual insurance has paid. Oklahoma Wesleyan University is not responsible for payment of any medical bills.

Signed: ____________________________ Date: ____________________________
[Parent(s) or legal guardian(s)]

[Printed Name(s) of Parent(s) or legal guardian(s)]
(print date of birth of student)

Address: ____________________________

Student Allergies: __________________
Current Medications: ________________

Country: ____________________________ Known Illness (es) or Disease (s):

Telephone Number: __________________

NOTARY PUBLIC Date
(Please sign, date, and affix seal or stamp)
Subscribed and sworn to/before me a Notary Public in and for the County of __________________________________________

My commission number: __________________ My commission expires: ________________

Please return this completed form to:
Student Health Department
Oklahoma Wesleyan University
2201 Silver Lake Road
Bartlesville, OK 74006
918-335-6264

Updated March 2017