



**WESTFIELD STATE UNIVERSITY
STUDENT HEALTH FORM**
www.westfield.ma.edu/healthservices

Upload your completed health forms and records here!



Health History Form

A **HOLD** will be placed on your student account, unless **ALL** required **Immunizations** and **Physical Examination** are submitted by July 1st for Fall enrollment and or Dec 1 for Spring enrollment

PLEASE PRINT

Name: Last		First	M.I.	Date of Birth	Student ID# A...	
WSU Year of Grad _____		Undergraduate <input type="checkbox"/>	Graduate <input type="checkbox"/>			
Chosen Name: _____		Preferred Pronouns: He/Him <input type="checkbox"/>		She/Her <input type="checkbox"/>	They/Them <input type="checkbox"/>	
Sex assigned at birth: Male <input type="checkbox"/>		Female <input type="checkbox"/>	Gender Identity: Male <input type="checkbox"/>		Female <input type="checkbox"/>	Transgender <input type="checkbox"/>
		Non-Binary <input type="checkbox"/>	Other <input type="checkbox"/>			
Home Address: Street		City	State	Zip	Home Phone	Cell Phone
Emergency Contact: Name/Relationship				Home Phone	Business Phone	Cell Phone
Emergency Contact: Name/Relationship				Home Phone	Business Phone	Cell Phone
Health Insurance		Policy Number	Card Holder		Card Holder's Birthdate	
Primary Care Provider		Phone Number		Address		
Dentist		Phone Number		Address		

CONSENT and FINANCIAL RESPONSIBILITY:

I hereby give permission to Westfield State University Health Services to provide me (or the aforementioned student under 18 years of age) with general, non-surgical medical treatment and diagnosis, including, but not limited to, immunizations or other health care, as determined to be medically necessary and/or recommended by a Licensed Westfield State University Health Care Provider. Further, in the event of a medical emergency, when my emergency contact(s) identified above cannot be reached, I hereby give permission for Westfield State University Health Services to make treatment decisions for me (or the aforementioned student under 18 years of age). This may include, but is not limited to, recommendations and/or referrals (if deemed necessary) for additional diagnostic testing, further evaluation or treatment, either in the clinic or at an urgent care or emergency care center, which could potentially result in hospitalization. Finally, I understand that Westfield State University Health Services does not bill insurance for services provided on-site. Fees for any off-site services such as labs, imaging, or prescriptions will be billed directly to my insurance, and I accept full financial responsibility.

Signature of Student: _____
Required of all students

Date: _____

Signature of Parent of Legal Guardian: _____
Required for all students under the age of 18 years

Date: _____

MEDICAL HISTORY

ALLERGIES

Medication Allergies: YES NO

If you checked "YES", please list medication and reaction: _____

Other Allergies: Foods, seasonal, insects etc.: _____

MEDICATIONS

Please list all medications you take including prescriptions, over the counter and herbal supplements/vitamins:

Please check yes or no on each line.

History of:	Yes	No	History of:	Yes	No	History of:	Yes	No
Anemia			Gastrointestinal Problems			Strep Throat		
Asthma			Head Injury (Concussion)			Substance abuse/Alcoholism		
Back Injury/Problem			Headaches (Recurrent)			Nicotine use: Vape/pouches		
Blood Transfusion			Hearing Deficit			Tobacco Use		
Chickenpox: (Date if known)			Heart Problems			Cannabis use		
Contact Lenses			Hepatitis			Menstrual Disorder		
Depression/Anxiety			High Blood Pressure			Cancer		
Diabetes			Kidney Problems			Tuberculosis or positive test		
Disease/Injury of joints/bones			Learning Disability			Thyroid Disease		
Ear, Nose, Throat Problems			Mononucleosis			Urinary Tract Infection		
Eating Disorders			Seizures			Birth Control		
Eye Problems			Sickle Cell Trait/Disease			Other (not listed)		
Fainting			Skin Condition:			Other (not listed)		

If you answered "YES" or "OTHER" to any of the above conditions, please provide additional information:

Please list and date any surgeries:

Please list and date any hospitalizations:

MENTAL HEATH HISTORY

History of:	YES	NO
Anxiety		
Depression		
Bipolar Disorder		
ADD/ADHD		
ODD		
Other (not listed)		
Do you have a therapist/counselor		

If you answered "YES" or "OTHER" to any of the above conditions, please provide additional information:

Have you ever been hospitalized for a mental health concern? If "YES" please provide date and reason:

Any special needs of student: Nature of Disability/Special medical needs:

Student's Signature

Date

TO THE STUDENT: This information is confidential & will not be released without your knowledge and written consent. The University will not be liable for any medical history information that is omitted from this form.

**Upload your completed health
forms and records here!**

