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## ENROLLMENT HEALTH RECORD

Dear Student,

Completing this form will permit the Health Services Office to offer you better care during your study at LAU. The following information is strictly confidential and will not be released to anyone without your consent. Please have this form completed by your physician and return it to the HEALTH SERVICES OFFICE.

**PERSONAL DATA**

Student ID # : ..... Major: .....

Family name: ..... First name: ..... Middle name: .....

Date of birth: ..... Place of birth: .....  
 (Month/Day/Year)

Nationality: 1 ..... 2 ..... Sex:  Male  Female

Current address: .....

LAU Residence Hall:  Yes  No Tel # : .....

Email: ..... Mobile # : .....

**PERSON(S) TO CONTACT IN THE EVENT OF AN EMERGENCY**

Name: ..... Relationship: .....

Address: .....

Home phone # : ..... Office phone # : ..... Mobile # : .....

Email: .....

**MEDICAL INSURANCE INFORMATION**

Insurance company name & address: .....

Policy # : ..... Expiry date: .....

Blood type :  A  B  AB  O

Rh :  +ve  -ve

Height: ..... cm Weight: ..... Kg BP: ..... mm/hg

**MEDICAL CONDITION**

<b>Allergic reactions:</b>	No	Yes	If yes, please give relevant details
Medications	<input type="checkbox"/>	<input type="checkbox"/>	.....
Pollen	<input type="checkbox"/>	<input type="checkbox"/>	.....
Food	<input type="checkbox"/>	<input type="checkbox"/>	.....
Insect	<input type="checkbox"/>	<input type="checkbox"/>	.....
Other	<input type="checkbox"/>	<input type="checkbox"/>	.....

**Hospitalization:**

Have you ever been hospitalized?  Yes  No

If yes, please list year and condition: .....

**Medication:** (please include over-the-counter drugs, herbal, or vitamins.)

Are you currently on medication?  Yes  No

If yes, please list the medication(s): .....

**HEALTH HISTORY**

Have you ever HAD or do you NOW HAVE any of the following ?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies /Hay fever        | <input type="checkbox"/> Frequent headaches/ Migraine | <input type="checkbox"/> Mumps                    |
| <input type="checkbox"/> Anemia                      | <input type="checkbox"/> Frequent sinusitis           | <input type="checkbox"/> Rapid or irregular pulse |
| <input type="checkbox"/> Anxiety / panic attack      | <input type="checkbox"/> Gastric reflux               | <input type="checkbox"/> Recent weight gain/loss  |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Glasses/contact lenses       | <input type="checkbox"/> Recurrent back pain      |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Head injury                  | <input type="checkbox"/> Rheumatic fever          |
| <input type="checkbox"/> Attention/learning disorder | <input type="checkbox"/> Heart murmur                 | <input type="checkbox"/> Rubella                  |
| <input type="checkbox"/> Back pain                   | <input type="checkbox"/> Hearing problem              | <input type="checkbox"/> Scarlet fever            |
| <input type="checkbox"/> Bleeding / hemophilia       | <input type="checkbox"/> Hepatitis                    | <input type="checkbox"/> Shortness of breath      |
| <input type="checkbox"/> Bowel problems              | <input type="checkbox"/> Hernia                       | <input type="checkbox"/> Smoking habit            |
| <input type="checkbox"/> Chronic cough               | <input type="checkbox"/> High or low blood pressure   | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Depression                  | <input type="checkbox"/> Infectious mononucleosis     | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Diabetes mellitus           | <input type="checkbox"/> Jaundice                     | <input type="checkbox"/> Ulcer                    |
| <input type="checkbox"/> Dysmenorrhea                | <input type="checkbox"/> Kidney stones                | <input type="checkbox"/> Unusual fatigue          |
| <input type="checkbox"/> Eating disorder             | <input type="checkbox"/> Loss of consciousness        | <input type="checkbox"/> Varicella (chicken pox)  |
| <input type="checkbox"/> Epilepsy or convulsion      | <input type="checkbox"/> Measles                      | <input type="checkbox"/> Vision/eye problem       |
| <input type="checkbox"/> Fractures                   | <input type="checkbox"/> Mediterranean fever          |   |

**MEDICAL CONDITIONS**

Do you have a chronic medical condition that requires treatment or medications?  Yes  No

If yes, please submit a physician’s report that includes the following:

Condition being treated: .....

Type of medication: .....

Physician’s address and phone number: .....

**REQUIRED PROOF OF IMMUNIZATIONS:**

MMR (Measles, Mumps, Rubella)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date dose 1: .....
			Date dose 2: .....
* Tetanus (booster within last 10 years)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
Polio	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
Varicella	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
Hepatitis B	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date dose 1: .....
			Date dose 2: .....
			Date dose 3: .....
* Hepatitis A	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date dose 1: .....
			Date dose 2: .....
* Meningococcal Vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
	Menactra <input type="checkbox"/>	Nimenrix <input type="checkbox"/>	Mencevax <input type="checkbox"/>
			Other : .....
Influenza Vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
BCG vaccine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date : .....
PPD result	Injection date: .....	Diameter ..... mm	Date: ..... Not done <input type="checkbox"/>
	(within the past 12 months)		

- \* Tetanus vaccine is mandatory to all students in the School of Architecture and Design.
- \* Hepatitis A vaccine is mandatory to all students in Residence Halls.
- \* Meningococcal vaccine is mandatory to all students in Residence Halls unless received after the age of 12.

**Physician’s Signature & Stamp :** .....

**Date:** .....

**Student’s Signature :** .....

**Date:** .....