



ENROLLMENT HEALTH RECORD

Dear Student,

Completing the Enrollment Health Record will permit the healthcare providers, physicians and nurses, at the LAU HEALTH Clinics to offer you better care during your study at the university. Please complete this form by your own physician or your campus HEALTH clinics' physician and submit it to the clinics' staff. To book an appointment, please contact:

Beirut campus:

Tel: + 961 1 78 64 64, Ext. 3007
 lauhealthclinic.beirut@lau.edu.lb

Byblos campus:

Tel: + 961 9 54 72 54, Ext. 3004
 lauhealthclinic.byblos@lau.edu.lb

The following information is strictly confidential and will not be released to anyone without your consent.

PERSONAL DATA

Student ID #: Major: Campus: Beirut Byblos

Family name: First name: Middle name:

Date of birth: Sex: Female Male
Day / Month / Year

Current address:

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

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

Name: Relationship:

Address:

Home phone #: Office phone #: Mobile #:

MEDICAL INSURANCE INFORMATION

Insurance company name:

MEDICAL INFORMATION

Blood Type: A B AB O Rh: Pos Neg

ALLERGIC REACTIONS	Yes	No	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"/>

SMOKING	Yes	No	If yes, how many
Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>
Vapes	<input type="checkbox"/>	<input type="checkbox"/>
Hubble Bubble	<input type="checkbox"/>	<input type="checkbox"/>

If yes, at what age did you start smoking?

Are you thinking about quitting?

HOSPITALIZATION

Have you ever been hospitalized? Yes No

If yes, please list year and reason

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:

HEALTH HISTORY

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Mediterranean fever |
| <input type="checkbox"/> Anxiety / panic attack | <input type="checkbox"/> Epilepsy or convulsion | <input type="checkbox"/> Musculoskeletal disease |
| <input type="checkbox"/> Arrhythmia or tachycardia | <input type="checkbox"/> Frequent headaches/ Migraine | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Attention/learning disorder | <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Varicella (<i>chicken pox</i>) |
| <input type="checkbox"/> Bleeding / hemophilia | <input type="checkbox"/> Hepatitis | Date: |
| <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Vision/eye problem |
| <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Loss of consciousness | |

REQUIRED PROOF OF IMMUNIZATIONS

- | | | |
|--|---|--|
| MMR (<i>Measles, Mumps, Rubella</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of doses: 1)..... 2)..... |
| *Tetanus (<i>booster within last 10 years</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |
| Polio | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |
| Varicella: history of disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |
| Varicella | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of doses: 1)..... 2)..... |
| Hepatitis B | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of doses: 1)..... 2)..... 3)..... |
| **Hepatitis A | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of doses: 1)..... 2)..... |
| ***Meningococcal vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of last 2 doses: 1)..... 2)..... |
| | <input type="checkbox"/> Menactra <input type="checkbox"/> Nimenrix <input type="checkbox"/> Mencevax | |
| Influenza vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |
| BCG vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |
| COVID-19 vaccine | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of doses: 1)..... 2)..... 3)..... 4)..... |
| | | Name of the vaccine: |
| PPD test (<i>within the past 12 months</i>) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Date:..... Result:..... |

* 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 16.

PHYSICAL EXAM

Height: cm Weight: kg BMI: BP: mm/hg HR:

Heart auscultation:

Lungs:

HEENT:

PHYSICIAN'S SIGNATURE & STAMP: DATE: / /

STUDENT'S SIGNATURE: DATE: / /