OKLAHOMA WESLEYAN UNIVERSTITY STUDENT HEALTH SERVICES!

The university provides one part-time physician and two part-time Registered Nurses who assist with the routine medical needs of the campus community. The Student Health Department is located in the La Quinta Mansion. Local physicians also act as consultants and referral sources for those who need special attention.

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 Student Health Department.

There are a few items needed for the student's medical file kept 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 are 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.

COPY OF INSURANCE CARD

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 January 25, 2023

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: ____ Date of Birth: ___________________
Address: ____ Place of Birth: ___________________
Male Female Social Security Number: ______________________ Religion: _____________Phone Number: _____________

In Case of an Emergency, Notify Responsible Party:

Name: ____
Address: ____
Phone Number: __________________________ Relationship to Student: ____________________________________
Medical Insurance Company: _______________________________________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
- ☐ German Measles (Rubella)
- ☐ Mumps/Scarlet Fever
- ☐ Rheumatic Fever/Malaria
- ☐ Infectious Mononucleosis
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ Diabetes Mellitus
- ☐ Cancer / Tumor / Cyst
- ☐ Asthma
- ☐ Exercise – Induced Asthma
- ☐ Shortness of Breath with exercise
- ☐ Pneumonia/Tuberculosis
- ☐ Recurrent Bronchitis
- ☐ Recurrent Ear Infection
- ☐ Frequent Colds
- ☐ Congenital Condition
- ☐ Rheumatic Heart Disease
- ☐ High Blood Pressure
- ☐ Heart Palpitations/Murmur
- ☐ Chest pain or pressure

- ☐ High Cholesterol
- ☐ Musculoskeletal Disorders
- ☐ Neurological Disorder
- ☐ Epilepsy
- ☐ Hepatitis A, B, or C
- ☐ Eating Disorder
- ☐ Drug/ Alcohol Dependency/ Abuse
- ☐ Panic/ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Mood Disorder/Depression
- ☐ Obsessive Compulsive Disorder
- ☐ Nervousness/Trouble Sleeping
- ☐ Hospitalized for Emotional Disorder
- ☐ Joint Injury/Bone Fractures
- ☐ Head Injury with loss of consciousness
- ☐ Concussion
- ☐ Fainting/Dizziness
- ☐ Seizure Disorder
- ☐ Recurrent Sinusitis or nosebleeds

- ☐ Vision Problems/Hearing Loss
- ☐ Thyroid Problems
- ☐ Inflammatory Bowel Syndrome
- ☐ Pancreatitis/Gall Bladder Problems
- ☐ Reflux
- ☐ Rectal Bleeding
- ☐ Hernia/Ulcer
- ☐ Recurrent Bladder Infection
- ☐ Bleeding / Blood Disorder
- ☐ Kidney Infection
- ☐ Chromic Kidney Disease
- ☐ Pelvic / Vaginal Infections
- ☐ Testicular Lump
- ☐ Irregular or painful periods
- ☐ Surgeries
- ☐ Chronic rash/Eczema/Hives
- ☐ Heat Related Illness
- ☐ Serious Accident / Injury
- ☐ Migraine or recurrent headaches
- ☐ Syncope or Fainting with exercise
- ☐ 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.

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__________________

____

CLINICAL EVALUATION

	Normal	Abnormal	Comments
1. Head, Ears, Nose, Throat			
2. Mouth, Teeth, Gums, Tonsils			
3. Neck and Thyroid			
4. Lungs / Chest			
5. Skin			
6. Heart			
7. Abdomen			
8. Genitalia			
9. Back/ Spine/ Bones/Joints			
10. Extremities / Musculoskeletal			
11. Neurological Motion Condition			
12. Emotional / Psychological			
13. Feet			
14. Other Findings			

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 January 25, 2023

Oklahoma Wesleyan University Record of Immunizations/Testing

A copy of your immunization record is preferred.

Immunization	Requirements	Date 1	Date 2	Date 3	Date4
Hepatitis B (Required by OK law)	Birth-2 months 1-4 months 6-18 months				
DTaP 5 doses unless 4th dose is after age 4, or for grades 6-12 3 doses	2 months 4 months 6 months 4-6 years				
DPT/HIB (Diphtheria-Tetanus acellular-Pertussis/ H. influenzae)	15 months must be fourth dose of DTaP & HIB				
HIB Haemophilus influenzae Type b3	2 months 4 months 6 months				
IVP Inactivated Poliovirus vaccine	2 months 4 months 15-18 months 4-6 yrs				
MMR (Required by OK law) 2 doses-first dose after first birthday	12-15 months 4-6 years				
Varicella (Chickenpox)	Must be at least 12 months of age				
PCV-7 (Pneumococcal Conjugate vaccine) Not required by state but highly recommended and given by state	2 months 4 months 6 months 12-15 months				
Hepatitis A Must be at least 2 years old 6-8 months between 1st & 2nd doses					

Meningococcal Meningitis	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.
	Date:

A TB Skin Test is recommended	Date of test:	Results:
TB Skin Test is mandatory for International Students		

CERTIFICATE OF EXEMPTION

NAME **DATE OF BIRTH**

PERMANENT ADDRESS **CITY** **STATE** **ZIP CODE**

REASON FOR OBJECTION:

1. MEDICAL CONTRAINDICATION:

I hereby certify that the immunization(s) specified below is/are medically contraindicated for the named student.

IMMUNIZATION IMMUNIZATION

CONTRADICTION SPECIFICATIONS SIGNATURE OF PHYSICIAN

2. **RELIGIOUS OBJECTION:**

I hereby certify that immunization is contrary to the teachings of the above named student's religion. I also understand that in the event of a disease outbreak at the university I may have to excluded for my protection and for the protection of the other students at the university.

____
Signature of Student (or parent if student is a minor)

3. **PERSONAL OBJECTION:**

I hereby certify that immunization is contrary to my beliefs. I request an exemption to he immunization requirements for Oklahoma colleges and universities. I have written a brief summary of my objections in the space provided below. I understand that lost records are not grounds for an exemption. I also understand that in the event of a disease outbreak at the university I may have to be excluded for my protection and for the protection of the other students at the university.

Briefly summarize your objections in this space: ________________________________

____

____
Signature of Student (or parent if student is a minor)

4. **Please check which immunizations this exemption applies to:**

[ ] MMR (Measles, Mumps, Rubella)
[ ] DTaP/TD (Diphtheria, Tetanus, and Pertussis)
[ ] Meningitis (For students living in residents halls
[ ] Polio
[ ] Hepatitis B
[ ] Received and reviewed information on risks associated with meningococcal disease
[ ] Received information on availability of vaccine against meningitis

____
Signature of student (or parent if student is a minor)

Student Health Department Consent Form for Emergency Treatment

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)

Updated January 25, 2023

Return to all Health Forms to Student Health Services

Address: ____

____

Country: ____

Telephone Number: ________________________________

Student Allergies:____________________

Current Medications:_________________

____

Known Illness (es) or Disease (s):

____

____

____

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