Name: _____

PUC ID#: _____

HEALTH INFORMATION FORM

Pacific Union College

Return this form to:
Pacific Union College
Health Services
One Angwin Avenue
Angwin, CA 94508
Attn: Health Services

Phone (707) 965-6339
Fax (707) 965-6243

To avoid delays please submit form for:
Fall Quarter: by Aug. 1
Winter Quarte: by Nov. 15
Spring Quarter: by Feb. 1
Summer Quarter: by May 15

Please complete form in its entirety before submission

Check one of the following:

☐ First Year (never attended PUC before). Starting quarter: ☐ Fall ☐ Winter ☐ Spring ☐ Summer

☐ Returning Student (last school year attended _____)

PLEASE PRINT IN INK

Full Legal Name:

_____
Last First Middle

Date of Birth: _____ / _____ / _____ Sex: _____ Social Security No.: _____

Street Address: _____

City/State/Zip: _____

Home Phone: _____ Cell Phone: _____

Next of kin or person to be notified in emergency (off campus):

Name: _____ Relationship: _____

Street Address: _____

City/State/Zip: _____ Home Phone: _____

Work Phone: _____

Person to be notified in emergency (on campus):

Name: _____ Phone: _____

Insurance Information

Whether or not you have existing insurance you are required to go to **aetnastudenthealth.com/puc** to complete the process to waive out or enroll in the Aetna Student Health plan. To successfully complete this requirement you must be enrolled, taking 6 or more units, and accessing the website during the correct timeframe (30 days prior to two weeks after instruction begins). For more details please go to **puc.edu/campus-services/student-health-insurance** (707) 965-6339 or contact Aetna customer service at (877) 480-4161 8:30 a.m.-5:30 p.m. EST. It is no longer necessary to submit a copy of your existing insurance in lieu of the above requirement.

CHILDHOOD IMMUNIZATION RECORD: Please submit with your health documents a copy of your childhood immunizations. Please be aware that all news/transfer students must have a TB skin test within one year of your first quarter at PUC. This can be obtained either through your primary care physician or our office once you arrive on campus.

MEDICAL INFORMATION

List any allergies to medication: _____

List all medication taken regularly: _____

List all major injuries/hospitalizations: _____

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PERSONAL HISTORY

If you mark "Yes" to any item please give dates.

Yes	No		Yes	No		Yes	No	
☐	☐	Alcoholism	☐	☐	Fainting spells	☐	☐	Poliomyelitis
☐	☐	Allergies	☐	☐	Fatigue	☐	☐	Rheumatic fever
☐	☐	Anemia	☐	☐	German measles	☐	☐	Scarlet fever
☐	☐	Arthritis	☐	☐	Glandular disorder	☐	☐	Sinusitis
☐	☐	Asthma	☐	☐	Hay fever	☐	☐	Sleeplessness
☐	☐	ADD/ADHD	☐	☐	Headaches	☐	☐	Sore throat (frequent)
☐	☐	Back trouble	☐	☐	Hepatitis	☐	☐	Suicide attempts
☐	☐	Brain concussion	☐	☐	Hernia or rupture	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	High blood pressure	☐	☐	Tuberculosis
☐	☐	Chickenpox	☐	☐	Influenza	☐	☐	Typhoid
☐	☐	Colds (frequent)	☐	☐	Jaundice	☐	☐	Ulcers (stomach/duodenal)
☐	☐	Colitis	☐	☐	Measles	☐	☐	Whooping cough
☐	☐	Constipation	☐	☐	Meningitis	☐	☐	Born or raised in foreign country
☐	☐	Depression	☐	☐	Mental illness			
☐	☐	Diabetes	☐	☐	Mononucleosis			Where? _____
☐	☐	Eating disorder	☐	☐	Mumps			_____
☐	☐	Eczema	☐	☐	Nervousness	☐		Other _____
☐	☐	Epilepsy	☐	☐	Pneumonia			_____

FAMILY HISTORY

Check (X) in box indicating the illnesses your blood relatives have or have had (Indicate which relative):

☐ Alcoholism	☐ Depression	☐ Obesity (20 lbs overweight)
☐ Allergies	☐ Diabetes	☐ Peptic ulcer
☐ Anemia	☐ Epilepsy	☐ Sickle cell anemia
☐ Arthritis	☐ Heart disease	☐ Suicide or attempts
☐ Asthma	☐ High blood pressure	☐ Thyroid disease
☐ ADD/ADHD	☐ Kidney disease	☐ Tremors, palsy
☐ Bleeding trait	☐ Leukemia	☐ Tuberculosis
☐ Cancer	☐ Mental illness	☐ Other
☐ Colitis	☐ Migraine headaches	☐ Other
☐ Congenital defect	☐ Nervous breakdown	☐ Other

Student's Signature: _____

Date: _____

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Name: _____

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CONSENT FOR TREATMENT/FINANCIAL RESPONSIBILITY/ RELEASE OF INFORMATION / NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I give my consent for medical treatment provided by the health services office of Pacific Union College.
I certify all submitted medical documents are correct.

I understand to be an enrolled student at PUC I am responsible to carry my own primary medical insurance plan and it is my responsibility to verify with my carrier adequate coverage in the Napa Valley. I understand PUC is not responsible for payment (either primary and/or secondary) for services received off campus.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) is a federal program that requires that all medical records and health information used by us in any form are kept confidential. This act gives patients seen significant new rights to understand and control how your health information is used. HIPPA provides penalties for misuse of personal health information. If you wish to review these rights we can provide you with a copy of the HIPPA Privacy Practice through our office.

You have the following rights with respect to your health information:

- The right to access, inspect, and request a copy of your health records.
- The right to request an amendment to your health information.
- The right to receive and account for certain disclosures of your health information.
- The right to receive confidential communications.
- The right to request restrictions on disclosures concerning your health information.

I hereby consent that medical information and treatment can be discussed with the following person/persons. (If you request information to be discussed only with you please leave the following section blank).

Name: _____ Date: _____

Relationship to student: _____

Name: _____ Date: _____

Relationship to student: _____

Name: _____ Date: _____

Relationship to student: _____

Signature of student (over 18): **X** _____ Date: _____

Signature of parent (under 18): **X** _____ Date: _____

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Name: _____

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PHYSICAL EXAMINATION

The following to be completed by doctor's office staff. All information below is required. Please do not leave any section blank. We cannot accept "not applicable" in any category listed below.

Height: _____ **Weight:** _____

Hearing Evaluation:

Right: _____ Left: _____

Vision Screening:

Without glasses/With glasses (circle)

Right: _____ / _____

Left: _____ / _____

Vital Signs:

T: _____

P: _____

R: _____

B/P: _____

TB Test (within the last year)

Lot #: _____ Exp.: _____

Date given: _____ Date read: _____

Induration/reading: _____

Read by: _____

If you have recently been out of the United States, please have one done now. PPD must be negative-10mm or less.

Date of last chest X-ray: _____

Results: _____

Current Medications: _____

_____

Nurse's Signature: _____

Remarks (please describe each abnormality): _____

_____

_____

_____

_____

_____

Date of examination: _____

To be filled out by physician:

Normal	Clinical Evaluation	Abnormal
	Head, Face, & Scalp	
	Nose & Sinuses	
	Neck	
	Mouth & Throat	
	Ears	
	Eyes	
	Lungs & Chest	
	Breast	
	Heart	
	Vascular System	
	Abdomen	
	Rectum	
	Endocrine	
	G.U. System	
	Extremities	
	Musculoskeletal	
	Skin	
	Neurological	
	Emotional	

Physician's Signature: _____ Date: _____

Name of physician: _____ Street Address: _____

City/State/Zip: _____ Phone: _____ Fax: _____

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