

Wyoming Seminary

Founded 1844

College Preparatory School, Kingston, Pennsylvania 18704-3539

Medical History – To be completed by parent or guardian before going to your physician.

Student's name: _____ Sex: ____ M ____ F
Last First Middle

Home Address: _____ Date of Birth: _____
Street City State Zip

Father's Name: _____ Home phone: () _____
Last First Middle

Address: _____ Work Phone: () _____
Street City State Zip

Mother's Name: _____ Home phone: () _____
Last First Middle

Address: _____ Work Phone: () _____
Street City State Zip

Family Medical History

List any disease which have occurred in the family, such as:

Tuberculosis _____
 Diabetes _____
 Epilepsy _____
 Asthma _____
 Other _____

List the death of either parent or sibling. Please include cause of death and date: _____

Student's Medical History

	Yes	No		Yes	No		Yes	No
Congenital defects			Measles	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Allergies			Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	other _____	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	Meningitis	<input type="checkbox"/>	<input type="checkbox"/>	Operations		
Drug	<input type="checkbox"/>	<input type="checkbox"/>	Infectious			Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Illness			Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma med: _____			Poliomyelitis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Concussion or Head injury:		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>			
Encephalitis	<input type="checkbox"/>	<input type="checkbox"/>						
German Measles	<input type="checkbox"/>	<input type="checkbox"/>						

- Additional information Yes No
- A. Has student's physical activity been restricted in the past five years
 Give reasons and duration _____
- B. Has student received treatment or counseling for a nervous conditions, personality disorder, Controlled substance abuse, or emotional problems.
 Give reasons and duration _____
- C. Has the student had any illness or injury or been hospitalized other than already noted.
 Give reasons and duration _____

In the event the student lacks the documentation of the needed immunizations, I give the health and medical care officials of Wyoming Seminary permission to administer vaccinations as necessary.
 I also give my permission to Wyoming Seminary to share this information, as needed, in order to ensure the health and safety of my child.

 Parent's Signature Date Physician's Signature(Acknowledging review) Date

Wyoming Seminary Immunization Requirements

Please provide dates for the following immunizations required for admission to Wyoming Seminary:

*** Parents please note the Tdap, Varicella and MCV vaccines were newly mandated in 2009. Check with your family doctor to make certain your child meets current state requirements.*

- **4 doses of DTap, DTP, or Td**

1st) _____ 2nd) _____ 3rd) _____ 4th) _____ 5th) _____

- **3 doses of Polio**

1st) _____ 2nd) _____ 3rd) _____ 4th) _____

- **2 doses of MMR (measles, mumps & rubella)**

1st) _____ (must be given after 12 months of age)

2nd) _____

If vaccines were given as individual doses please provide the dates.

Measles - 1st) _____ (must be given after 12 months of age) 2nd) _____

Mumps - _____

Rubella - _____

Titers are also accepted if student contracted disease before immunization. Please attach lab reports to this form.

- **3 doses of Hepatitis B**

1st) _____ 2nd) _____ 3rd) _____

- ****2 doses of varicella (chickenpox) or history of chickenpox**

1st) _____ 2nd) _____

Date of diagnosed chickenpox - _____

- ****1 dose of Tdap (if 5 years has elapsed since last tetanus immunization)**

1st) _____

- ****1 dose of MCV (meningococcal conjugate vaccine)**

1st) _____

Wyoming Seminary Immunization requirements are in compliance with mandates set by the State of Pennsylvania.

