Student Health Center
1300 Badger Street
La Crosse, WI 54601
Telephone: (608) 785-8558; FAX: (608) 785-8746
www.uwlax.edu/studenthealth

Name (Last)		(First)	(Middle)	
Birth Date	Sex O M O F	Permanent Address	Telephone Number	Student I.D.

Immunization Record

TD / Tdap (please specify)	Most Recent Date:			A booster dose is recommended every 10 years.
MMR measles, mumps rubella	First Dose-Date:	Second Dose-Date		Two doses recommended. Indicate month/year for all doses after age 12 months. Not needed if student born before 1957.
Varicella (chicken pox)	First Dose-Date:	Second Dose-Date	or date of disease	Recommended for all students who have not had the disease in childhood.
Hepatitis A	First Dose-Date:	Second Dose-Date		A 2-dose series is recommended for persons at increased risk and for international travel.
Hepatitis B	First Dose-Date:	Second Dose-Date	Third Dose-Date	Recommended for all students. Required for students in education majors and those entering health care fields.
Meningitis	Date dose given:			Recommended for entering freshman, dormitory residents or immunocompromised.
TB Test	Most Recent Date:	Results: O Pos (chest x-ray required) O Neg		Recommended for all students.
Influenza (flu shot)	Most Recent Date:			Recommended annually for all students.
	Date:	Date:	Date:	List other immunizations.
HIB				
Polio				
HPV				

Can attach a recent copy of your state's Immunization Registration

Emergency Notification

Specify parent(s) / guardian(s) to be notified in case of emergency

Name ____ **Relationship**__________________

Telephone (home) _________________________ **(work)** _________________________

OR

Name ____ **Relationship**__________________

Telephone (home) _________________________ **(work)** _________________________

Health Information

Allergies **O Yes O No** **Please List:**

____
____
____

Medications **O Yes O No** **Please List:**

____
____
____

Chronic Illnessess (Asthma, Diabetes, etc.) **Please List:**

____
____
____

Health Insurance

Company ______________________________ **Telephone** _______________

Name of Policy Holder ______________________ **Policy Number** _______________

CONSENT FOR TREATMENT:

I hereby authorize any University of Wisconsin-La Crosse Student Health Center staff to render any emergency treatment, medical or surgical care deemed necessary to maintain health and well being even if treatment requires hospitalization at an accredited local hospital:

____ / ____ / ____ ____

Date Signature of Student

____ / ____ / ____ ____

Date Signature of parent or guardian if student is under legal age of 18