



Health Services

1025 North Broadway, K-254
Milwaukee, Wisconsin 53202
Phone: 414-277-7540
Fax: 414-277-2897

For Office Use Only:
Jenzabar: ___/___/___
MM DD YY (Initial)

Student Health Form

All **NEW students** to the university are **encouraged** to have a **Health Form** on file with Health Services before the start of your first term at MSOE. **Students living on campus are required to submit their Health Form prior to moving on campus.**

A. General Information

STUDENT ID # _____

Name: _____
Last Name First Name Middle

Date of Birth ___/___/___ Gender: Male Female Other Athlete

Resident Commuter Address: _____

Emergency Contact: _____
Name Relationship Phone Number

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Name Relationship Phone Number

Medical Insurance: _____
Company Policy Number Group Number Phone Number

*MSOE recommends that **all students have health insurance** and carry their insurance card with them at all times. Check with your insurance company for coverage in the Milwaukee Area. MSOE does offer health insurance for those who need it. Please see our Health Services website for more information.

B. Health Information

Any diagnosed medication conditions, mental health concerns, or disabilities?

Any history of hospitalizations? If so, when and what for?

Are you currently under the care of a physician?

Name: _____ Phone: _____

Are you currently under the care of a psychiatrist/psychologist?

Name: _____ Phone: _____

C. Immunizations

Wisconsin State Law (Assembly Bill 344) requires students to sign an acknowledgement statement related to Hepatitis B and Meningitis. Please refer to the enclosed document for more information on Hepatitis B and Meningitis.

My signature below verifies my receipt of the enclosed Hepatitis B and Meningitis information.

SIGNED _____ Date: _____

MSOE strongly recommends, but does not require, that new students receive the following immunizations. You may obtain dates and documentation from your health care provider, previous school records or your state immunization registry.

Wisconsin Immunization Registry: www.dhfwir.org

Need help finding immunization records, visit www.cdc.gov/vacines/programs/iis/index.html

Measles/Mumps/Rubella (MMR)	Date of First Dose	Date of Second Dose	
Varicella (Chicken Pox)	Date of First Dose	Date of Second Dose	OR Circle if history of Chicken pox YES
Tetanus/diphtheria/pertussis (T-dap) Tetanus-Diphtheria (Td)	Date of most recent dose	Circle one: Td T-dap	
Hepatitis B	Dose 1	Dose 2	Dose 3
Meningitis	Date of First Dose	Date of Second Dose, as needed	
Tuberculosis (TB)	Skin Test Date	Read Results	_____MM
Chest X-Ray for reactive TB test	Results		

**Students in enrolled in the MSOE Nursing Programs, Perfusion Program, Division III Athletics and/or are international students may be required to submit additional health and/or immunizations documentation. Please contact specific departments for additional information:*

Nursing Program:	Carla Brooks	414-277-7445	brooksc@msoe.edu
Perfusion Program:	Ron Gerrits	414-277-7561	gerrits@msoe.edu
Division III Athletics:	David Bugalski	414-277-2812	bugalski@msoe.edu
International Students:	Katie Toske	414-221-7852	toske@msoe.edu

I attest that the information supplied by me is true and complete to the best of my knowledge

Signature _____ Date _____

*If you have any questions or need information please contact:
Heath@msoe.edu or (414) 277-7540*