



# Health Record

Return to:  
Office of Admissions  
LeTourneau University  
P.O. Box 7001  
Longview, TX 75607-7001

**NOTICE:** Please complete this form clearly and with as much accuracy as possible. It is **mandatory** that it be returned to the *Office of Admissions* **before arriving** for registration. Should an accident or health problem occur, the availability of this record to the health provider could prevent unnecessary delay in your receipt of prompt treatment. Your health record is strictly confidential and released only at your direction. If you have any questions concerning the completion of the Health Record, please contact Shela Dawson, R.N. at (800) 759-8811 ext. 4445 or fax: (903) 233-4402 or email: [ShelaDawson@letu.edu](mailto:ShelaDawson@letu.edu).

## Personal Information

Name \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Street Address \_\_\_\_\_ Email: \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Name of Parent  or Spouse  \_\_\_\_\_ Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_

In case of accident or serious illness, notify: (Name) \_\_\_\_\_ (cell) \_\_\_\_\_

(Address) \_\_\_\_\_

(Email) \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

### Have you previously attended LeTourneau University? If so:

Year of entry: \_\_\_\_\_ Year of last enrollment: \_\_\_\_\_ Year and semester now entering: \_\_\_\_\_

## Personal History

Please answer all questions. Comment on all positive answers in space provided or attach sheets.

**ALLERGIES (food & drug):** \_\_\_\_\_  
(Explain reaction: \_\_\_\_\_)

Have you ever had:	Yes	No		Yes	No		Yes	No
<b>ADD</b> (If yes, see #6)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
<b>ADHD</b> (If yes, see #6)	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia/Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Rubella		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	(German Measles)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<b>Learning Disability</b>			Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	(If yes, see # 6)	<input type="checkbox"/>	<input type="checkbox"/>	Serious Depression	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Severe Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Cyst	<input type="checkbox"/>	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Pain/Pressure in Chest	<input type="checkbox"/>	<input type="checkbox"/>	Worry or Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury (with unconsciousness)	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
			Paralysis	<input type="checkbox"/>	<input type="checkbox"/>			

1. Has your health been  good,  fair,  poor? If not "good", explain: \_\_\_\_\_

2. List any physical, emotional, mental, relational or spiritual issues or problems about which the school should know to provide for your needs. \_\_\_\_\_

3. Has your physical activity been restricted during the past five years? (Give reasons and durations) Yes  No

**Personal History** (continued)

- |                                                                                                                                                                                                                                                                                |                                                          |                                                          |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------|
| 4. Have you had, or do you anticipate, difficulty with school, studies, teachers, or peers?<br>If yes, briefly explain: _____<br>_____                                                                                                                                         | Yes<br><input type="checkbox"/>                          | No<br><input type="checkbox"/>                           |
| 5. Have you every received treatment or counseling for a medical, psychological, social, or spiritual condition, disorder or problem?<br>If yes, briefly explain: _____                                                                                                        | <input type="checkbox"/>                                 | <input type="checkbox"/>                                 |
| 6. Were you tested for a learning disability, ADD, or ADHD? If yes, when: _____<br>Did you receive accommodations while in high school? Please specify: _____                                                                                                                  | <input type="checkbox"/><br><br><input type="checkbox"/> | <input type="checkbox"/><br><br><input type="checkbox"/> |
| 7. Have you had any illness or injury or been hospitalized other than already noted? (Give details)<br>_____                                                                                                                                                                   | <input type="checkbox"/>                                 | <input type="checkbox"/>                                 |
| 8. List any prescription medication you are currently taking. _____                                                                                                                                                                                                            |                                                          |                                                          |
| 9. Have you ever abused Alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/> ; Drugs? Yes <input type="checkbox"/> No <input type="checkbox"/> ; Tobacco? Yes <input type="checkbox"/> No <input type="checkbox"/><br>When? _____ Please specify treatment: _____ |                                                          |                                                          |

**REQUIRED IMMUNIZATIONS FOR ALL STUDENTS**

**Note:** **Td** is needed every 10 years following initial series.  
**Polio** update is requested for those traveling overseas. Students from outside the continental limits of the United States, who are without prior protection, are urged to get the Polio vaccine series.  
**2 MMR's** or proof of the diseases are required.  
**One TB Skin Test** is needed within a year of enrollment.

Immunizations	Dates Given	(or) Date of Disease
Diphtheria-tetanus (Td)		
Polio		
Mumps, measles rubella (MMR)	#1                      #2	
TB skin test		

\_\_\_\_\_  
**Signature of Physician or Nurse or enclose immunization record**

\_\_\_\_\_  
**Date**

**LETOURNEAU UNIVERSITY CONSENT FOR TREATMENT**

In case of serious illness or immediate need, I give LeTourneau University, or its representative, permission to acquire medical and/or mental healthcare for \_\_\_\_\_. This consent includes treatment, as deemed necessary by an attending physician or qualified mental health professional, and care in a hospital or other in-patient treatment facility if so advised. I understand and acknowledge that I am fully responsible for all expenses incurred in the treatment of this student. In the event of a less serious problem requiring minor care, I approve of treatment received through the campus Health Services and Counseling Services. This consent will be valid during this students' matriculation at LeTourneau University unless revoked in writing and sent to the Director of Health Services at LeTourneau University.

\_\_\_\_\_  
**Signature of Parent, Guardian, or Student of legal age**

\_\_\_\_\_  
**Date**

In compliance with the 77<sup>th</sup> Texas Legislature (2001) to notify all new students about bacterial meningitis (Chapter 51, Education code, Section 51.9191; Chapter 38, Education Code, Section 38.0025), this is to certify that I have received the **Important Information About Bacterial Meningitis** brochure.

\_\_\_\_\_  
**Signature of Parent, Guardian, or Student of legal age**

\_\_\_\_\_  
**Date**