



# Health Services

Health Record

1025 North Broadway, K250  
Milwaukee, Wisconsin 53202  
414-277-7590  
Fax: 414-277-2897  
[www.msoe.edu/health](http://www.msoe.edu/health)

Name: \_\_\_\_\_  
(Last, First, Middle Initial)

Welcome to MSOE! **All students new to the university are required** to have a **Health Record** on file with Health Services before the start of your first term at MSOE.

## A. GENERAL INFORMATION

STUDENT ID # \_ \_ \_ \_ \_

Name \_\_\_\_\_  
*Last Name* *First Name* *Middle*

Date of Birth     /    /     Gender:  MALE  FEMALE  
*MM DD YY*

Residence Hall \_\_\_\_\_ Cell or Campus Phone \_\_\_\_\_  
*Residence Hall Room Number*

If Commuter, Address: \_\_\_\_\_ Home Phone \_\_\_\_\_  
*Street City State Zip*

Permanent Home Address: \_\_\_\_\_ Home Phone \_\_\_\_\_  
*(if different from above) Street City State Zip*

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
*Name Relationship (Home, Business, Cell, etc.)*

Medical Insurance \_\_\_\_\_  
*Company Policy Number Group Number Phone # (Member Services)*

Expected Graduation Year \_\_\_\_\_

### Check all that apply:

- General Student**  FRESHMAN  SOPHOMORE  JUNIOR  SENIOR  PART-TIME  FULL TIME
- Transfer Student**
- Athlete** Please note that **Athletics requires additional forms.** 1-414-277-2812

- International Student** HOME COUNTRY \_\_\_\_\_
- Perfusion Student**  Copy sent to Perfusion Program Director  Copy sent to Health Services
- Nursing Student**  FIRST YEAR  IN CLINICAL ROTATION
- Nursing Faculty**  NEW  SUCCESSIVE

**Please return your Health Record and any attachments to:** by mail: MSOE Health Services K250, 1025 N. Broadway, Milwaukee, Wisconsin 53202; via fax: 414-277-2897; in person, 1245 N. Broadway, K250. Residence Hall students may submit Health Records at the time of their move-in date to Residence Hall staff.

MSOE recognizes that due to health or religious reasons, some students may not receive immunizations. If so, please have your physician and /or minister attach a statement addressing these issues to your Health Record. The University reserves the right to require additional health information if data submitted is considered to be inadequate.

### For Office Use/School of Nursing Purposes Only:

**Freshman/Transfer:** Record Complete  Immunizations Met

**Soph.:** Documentation annual TB     /    /     Form I-PE     /    /      
*MM DD YY MM DD YY*

**Junior:** Documentation annual TB     /    /     **Comments:**

**Senior:** Documentation annual TB     /    /     Form H. (if changes)     /    /         /    /      
*MM DD YY MM DD YY MM DD YY*

**Date Received:**     /    /     \_\_\_\_\_ **All Requirements Met**     /    /     \_\_\_\_\_  
*MM DD YY (initial) MM DD YY (initial)*

**Delinquency: Request Sent**     /    /     \_\_\_\_\_ **Jenzabar**     /    /     \_\_\_\_\_  
*MM DD YY (initial) MM DD YY (initial)*

**Comments:**