Taylor University
Student Health Record 2025-2026

Explanation and Instructions

All students entering Taylor University are required to submit this **completed health record** to the Taylor University Health Center **prior** to beginning classes. The health record requires a physical examination completed by a licensed healthcare provider **within one year of the first day of classes**. It is recommended that the physical examination be provided by a healthcare provider who is familiar with the student and his or her medical history.

This health record will be used solely for medical purposes and handled only by professional personnel concerned about your health. The purpose of this health record is:

- To provide information in the event of a medical emergency
- To assist the Health Center by providing information which may not be immediately obtainable from the student
- To indicate conditions for which a student may need care or assistance from the Health Center
- To assist chronically ill or physically challenged persons in making arrangements to facilitate their successful experience at Taylor University

Students/Parents complete all of page two and the top section of page three. Students, along with parents of students under the age of 18, need to sign the bottom of page three. The remainder of page three and all of page four need to be completed by a physician. Please make sure **all required** sections are completed and signed.

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Mail, fax, or email completed forms to:
Taylor University Student Development
Att: Bev Guffey
1846 Main Street
Upland, IN 46989
Fax (765) 998-4840
Phone (765) 998-5379

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PLEASE KEEP A COPY OF THESE COMPLETED FORMS FOR YOUR PERSONAL RECORDS

Please make sure this completed health record is received no later than:

Fall entry	**August 1**
Inter-term entry	**December 15**
Spring entry	**January 15**

Taylor University Student Health Record 2025-2026

Welcome to Taylor University. To meet many health care needs, Taylor upholds a partnership with the Indiana University Health Clinic conveniently located adjacent to the northeast end of campus. Students may receive evaluation and treatment by a nurse practitioner at no charge. Lab services are available on a fee for service basis. We hope we don't get to know you well while you are at Taylor, but we are here if you need us!

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Please have your doctor complete this form and return it to us *prior* to the first day of classes.

NAME: Last (Print) First MI Sex Date of Birth

HOME ADDRESS: City State Zip

Telephone Numbers: Home Cell Campus

Father's Name Daytime phone Father's Date of Birth

Mother's Name Daytime phone Mother's Date of Birth

Guardian's Name Daytime phone

Please enclose a photocopy of your immunization records and of BOTH sides of your medical insurance card.
***Note: If this information is not provided, any bill for services that would normally be billed to insurance will be sent directly to the parent's or guardian's home address.**

Medical History

(If you have a special health need, we encourage you to contact the health center prior to your arrival to discuss available accommodations.)

Have you had any of the following?

	Yes**	No
Difficulty sleeping		
Eating issues		
Depression		
Diabetes		
Asthma		
Hypertension		

	Yes**	No
Heart problems		
Surgery		
Seizures		
Broken bones		
Hospitalization		
Tuberculosis		

** Please explain any "yes" answers:

Do you take any medications on a regular basis? If yes, please list the name, dose, strength, and instructions for use. Include nutritional supplements, vitamins, and over-the-counter medications**.**

_____

Are you allergic to any medications? If yes, please list medication and nature of reaction (i.e., rash, trouble breathing, etc.)

Do you have any impairments or require the use of any assistive devices? _____

_____

Required Immunizations:

(You must fulfill these requirements prior to the first day of classes)

1) MMR vaccination
(At least 28 days apart after 12 months of age)
vaccine 1 _____/_____/_____ month day year
vaccine 2 _____/_____/_____ month day year

2) Td _____/_____/_____ month day year

Tdap _____/_____/_____ month day year
(within the last 10 years)

Tuberculosis screening:

Is the student a member of a high-risk group, lived outside of the United States in the last 5 years, or entering the health professions? If yes, please complete a TB skin test within the past year:

Date Given: _____/_____/_____

Date Read: _____/_____/_____

Results: mm of induration _____

Positive □ Negative □
(If positive please document evaluation and recommendations)

Recommended Immunizations:

Hepatitis B
dose 1 _____/_____/_____
dose 2 _____/_____/_____
dose 3 _____/_____/_____

Meningococcal
dose 1 _____/_____/_____
dose 2 _____/_____/_____

Meningitis B
dose 1 _____/_____/_____
dose 2 _____/_____/_____

Varicella
dose 1 _____/_____/_____
dose 2 _____/_____/_____
Date of Disease _____/_____/_____

Other Immunizations:

Polio (Last dose)
_____/_____/_____ month day year

Hepatitis A
dose 1 _____/_____/_____
dose 2 _____/_____/_____

Typhoid
Oral dose _____/_____/_____ or Injection dose _____/_____/_____

Yellow Fever ____/____/____

Other:

Consent for Treatment:

I have reviewed the above information and believe it to be accurate. I, the undersigned, authorize and consent to treatment. I understand that I may withdraw my consent at any time. Should I be under eighteen years of age, my parent's (or guardian's) signature below indicates approval and consent for medical treatment at the Student Health Center.

_____

Student Signature Parent or Guardian Signature Date

Physical Examination Name_____

Height _____Weight _____Blood Pressure_____/_____

Vision: Uncorrected Right _____Left _____Corrected: Right _____Left _____

Are there any abnormalities of the following systems?

Answer yes or no by check mark (√)	**Yes**	**No**
Head		
Eyes (other than acuity)		
Ears		
Nose		
Throat		
Lungs		
Heart		
Abdomen		
Genitourinary		
Hernia		
Musculoskeletal		
Metabolic/Endocrine		
Neurological		
Psychiatric		
Is there loss of seriously impaired function of any paired organ?		
Is the patient currently being treated for:		
Serious medical condition?		
Serious emotional condition?		
Do you have any recommendations regarding the care of this student?		
Are you the student's regular physician?		

Please explain any "yes" answers:

Recommendations for physical activity: Unlimited _____Limited _____(If limited explain:)
(Physical education, intramurals, and varsity sports)

Is there a medical contraindication to immunizations: No _____Yes _____
If yes, please explain) _____

Date of Exam: _____ Physician Signature:_____

Print Physician Name: _____ Physician telephone number:_____

Physician Address: _____

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