LAU
الجامعة اللبنانية الأميركية
Lebanese American University

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ENROLLMENT HEALTH RECORD

Dear Student,

Completing this form will permit the Health Services Office to offer you better care during your study at LAU. The following information is strictly confidential and will not be released to anyone without your consent.
Please have this form completed by your physician and return it to the HEALTH SERVICES OFFICE.

PERSONAL DATA

Student ID # : ..... Major: .....

Family name: ..... First name: ..... Middle name: .....

Date of birth: ..... (Month/Day/Year) Place of birth: .....

Nationality: 1 ..... 2 ..... Sex: ☐ Male ☐ Female

Current address: .....

LAU Residence Hall: ☐ Yes ☐ No Tel # : .....

Email: ..... Mobile # : .....

PERSON(S) TO CONTACT IN THE EVENT OF AN EMERGENCY

Name: ..... Relationship: .....

Address: .....

Home phone # : ..... Office phone # : ..... Mobile # : .....

Email: .....

MEDICAL INSURANCE INFORMATION

Insurance company name & address: .....

Policy # : ..... Expiry date: .....

Blood type : ☐ A ☐ B ☐ AB ☐ O

Rh : ☐ +ve ☐ -ve

Height: ..... cm Weight:. ..... Kg BP: ..... mm/hg

MEDICAL CONDITION

Allergic reactions:	No	Yes	If yes, please give relevant details
Medications	☐	☐	.....
Pollen	☐	☐	.....
Food	☐	☐	.....
Insect	☐	☐	.....
Other	☐	☐	.....

Hospitalization:

Have you ever been hospitalized ? ☐ Yes ☐ No

If yes, please list year and condition: .....

Medication: (please include over-the-counter drugs, herbal, or vitamins.)

Are you currently on medication? ☐ Yes ☐ No

If yes, please list the medication(s): .....

HEALTH HISTORY

Have you ever HAD or do you NOW HAVE any of the following ?

- ☐ Allergies /Hay fever
- ☐ Anemia
- ☐ Anxiety / panic attack
- ☐ Arthritis
- ☐ Asthma
- ☐ Attention/learning disorder
- ☐ Back pain
- ☐ Bleeding / hemophilia
- ☐ Bowel problems
- ☐ Chronic cough
- ☐ Depression
- ☐ Diabetes mellitus
- ☐ Dysmenorrhea
- ☐ Eating disorder
- ☐ Epilepsy or convulsion
- ☐ Fractures
- ☐ Frequent headaches/ Migraine
- ☐ Frequent sinusitis
- ☐ Gastric reflux
- ☐ Glasses/contact lenses
- ☐ Head injury
- ☐ Heart murmur
- ☐ Hearing problem
- ☐ Hepatitis
- ☐ Hernia
- ☐ High or low blood pressure
- ☐ Infectious mononucleosis
- ☐ Jaundice
- ☐ Kidney stones
- ☐ Loss of consciousness
- ☐ Measles
- ☐ Mediterranean fever
- ☐ Mumps
- ☐ Rapid or irregular pulse
- ☐ Recent weight gain/loss
- ☐ Recurrent back pain
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Shortness of breath
- ☐ Smoking habit
- ☐ Thyroid disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Unusual fatigue
- ☐ Varicella (chicken pox)
- ☐ Vision/eye problem

MEDICAL CONDITIONS

Do you have a chronic medical condition that requires treatment or medications? ☐ Yes ☐ No

If yes, please submit a physician's report that includes the following:

Condition being treated: .....

Type of medication: .....

Physician's address and phone number: .....

REQUIRED PROOF OF IMMUNIZATIONS:

MMR (Measles, Mumps, Rubella)	Yes ☐	No ☐	Date dose 1: .....
			Date dose 2: .....
* Tetanus (booster within last 10 years)	Yes ☐	No ☐	Date : .....
Polio	Yes ☐	No ☐	Date : .....
Varicella	Yes ☐	No ☐	Date : .....
Hepatitis B	Yes ☐	No ☐	Date dose 1: .....
			Date dose 2: .....
			Date dose 3: .....
* Hepatitis A	Yes ☐	No ☐	Date dose 1: .....
			Date dose 2: .....
* Meningococcal Vaccine	Yes ☐	No ☐	Date : .....
	Menactra ☐	Nimenrix ☐	Mencevax ☐ Other : .....
Influenza Vaccine	Yes ☐	No ☐	Date : .....
BCG vaccine	Yes ☐	No ☐	Date : .....

PPD result Injection date: ..... Diameter ..... mm Date: ..... Not done ☐
(within the past 12 months)

* Tetanus vaccine is mandatory to all students in the School of Architecture and Design.
* Hepatitis A vaccine is mandatory to all students in Residence Halls.
* Meningococcal vaccine is mandatory to all students in Residence Halls unless received after the age of 12.

Physician's Signature & Stamp : .....

Date: .....

Student's Signature : .....

Date: .....