SALVE REGINA UNIVERSITY HEALTH FORM

100 Ochre Point Avenue • Newport, Rhode Island 02840-4129 • p: 401-341-2904 • f: 401-341-2934

TO ALL STUDENTS, PARENTS, HEALTH CARE PROVIDERS: **This completed health form must be returned to Health Services by July 1 (Please mail or fax one copy only)**. Please be candid on this form. This is a highly confidential document for the sole use of the professional staff at Health Services. No information on this form will be released without the student's written consent. Remember to fill out the entire form to avoid any unnecessary delay when you arrive on campus to check-in. The state required immunizations are of particular importance.

PERSONAL INFORMATION (Please Print)

Full Name: ____
Last First Middle Student ID #

Preferred Name: ______________________ Social Security #: ______________

Date of Birth: __________ Sex: __________ Entrance Year: ______ Class: (Circle One) FR SO JR SR

Place of Birth: ______________________ How Long have you lived in the USA: __________

Home Address: ____
Street City State Zip Code

Home Phone: ______________________ Student Cell Phone: ______________________

PERSON TO BE NOTIFIED IN AN EMERGENCY

Name: ______________________ Relationship: ______________________

Address: ____
Street City State Zip Code

Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

INSURANCE INFORMATION

PLEASE ATTACH A COPY OF THE FRONT & BACK OF HEALTH INSURANCE PLAN CARD, PRESCRIPTION PLAN CARD AND DENTAL PLAN CARD

Please provide your son/daughter with a card for your health insurance, prescription plan and dental plan.

Insurance Company Name: ______________________ Policy #: ______________

Claims Address: ____
Street City State Zip Code

Subscriber Name: ____

Is Pre-authorization required? Yes No Phone Number for Pre-authorization: ______________

Prescription Plan Name and Number: ____

Phone Number for Prescription Authorization: ____

CONFIDENTIAL MEDICAL HISTORY

To Be Completed By Student/Reviewed by Provider

Name: ____ Date of Birth:________________

Please circle any of the following conditions you have had; explain and give dates as needed.

Acne / Eczema / Allergic skin disease
Asthma / Bronchitis / Pneumonia / Tuberculosis
Ear infections /Tonsillitis / Sinusitis / Seasonal allergies
Mononucleosis / Liver or Spleen injury
Heart murmur / Heart condition
High blood pressure / Low blood pressure / Phlebitis (blood clot)
Appendectomy / Hernia
Diarrhea (chronic) / Blood in the stool / Parasitic infection
Hepatitis; Type: A B C / Ulcer / Ulcerative colitis / Crohn's disease
Cystitis (bladder infection) / Blood/ Protein in urine
Nephritis (kidney infection) / Loss of kidney
Amenorrhea (missed periods) / Dysmenorrhea (painful periods)
Fractured bones / Severe sprains / Ligament injuries / Back pain / Joint pain
Diabetes / Thyroid disease / Anemia / Sickle cell disease or trait
Seizures / Severe headaches / Dizzy or fainting spells / Concussion
Depression / Anxiety / Bipolar / ADD / Eating disorders / Counseling: yes / no
Head injury / Loss of consciousness / Eye injury / Eye loss

Have you had Chicken Pox? No Yes Date of disease:

Additional comments or problems (please list any surgery or hospitalizations)________________________________

____

Any ethnic/religious/gender considerations we should know about? No Yes

CURRENT MEDICATIONS: (including vitamins and birth control pills)________________________________

____

ALLERGIES: (food, insect, medication)____

SECTION B

Have you experienced any of the following during or immediately after exercise?

Fainting	☐ No	☐ Yes	Unusual Fatigue	☐ No	☐ Yes	Dizzy or light headed	☐ No	☐ Yes
Chest Pain	☐ No	☐ Yes	Heart Racing	☐ No	☐ Yes	Shortness of Breath	☐ No	☐ Yes
Hives	☐ No	☐ Yes						

Has any blood relative had any of the following conditions: (including parents, siblings, grandparents, aunts, uncles. explain below.)

Early death (Give age and reason) ____

Heart attack/surgery (Give age) ____

Cardiomyopathy (abnormal heart structure) ____

Marfan's syndrome ____

Prolonged QT interval or arrhythmia ____

HEALTH BEHAVIORS	NO	YES
a. Do you smoke? # cigs/day		
b. Do you chew tobacco?		
c. Have you ever worried about your alcohol use?		
d. Have you ever worried about your drug use?		
e. Do you worry too much about your weight?		
f. Do you have any unhealthy weight control issues		
g. Do you exercise?		
h. If sexually active do you use condoms?		
i. (Men) Do you examine your testicles monthly?		

BIOLOGICAL FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

MEDICAL CARE AUTHORIZATION

"I, the undersigned, hereby specifically authorize University Health Services and/or any authorized member of the staff, or duly affiliated consultant, to provide care in the University Health Services, and for emergency treatment."

SIGNATURE IF UNDER 18 YEARS OF AGE, PARENTAL SIGNATURE IS ALSO REQUIRED

____

Student Date

____

Parent Date

IF YOU HAVE A SERIOUS MEDICAL CONDITION/DISABILITY, PLEASE COMPLETE

University Health Services would like to notify appropriate departments of your serious medical condition/disability in order to be able to respond to an emergency that might arise as a result of your health problem.

I hereby authorize University Health Services to release information of my serious health problem which is

____ to:

Please check as appropriate:

- Salve Regina University Emergency Medical Technician/Safety and Security
- Food Services (food allergies)
- Residence Life Office
- Counseling
- Disabilities Office

This release is not to be construed as a release of any information other than that specified above, or for any other purpose than that specified above.

This authorization may be terminated by me in writing at any time.

Signed ____

Date ____

Name (please print) ____

Date of Birth ____

IMMUNIZATION RECORD

You will be unable to register for classes if you have not provided proof of required immunizations.

PART I - TO BE COMPLETED BY STUDENT

Name ____
Last First Middle

Home Address ____
Street City State Zip Code

Date of Birth ____________________ Social Security Number ____________________

Status Part-time Full-time Graduate Undergraduate

PART II - TO BE COMPLETED AND SIGNED BY HEALTH CARE PROVIDER *All information must be in English*

*** REQUIRED**

* M.M.R. (Measles, Mumps, Rubella)

(Two doses required at least 28 days apart for students born after 1956 and all health sciences students)

1. Dose 1 given at age 12 months or later #1 ____________________ Month Day Year
2. Dose 2 given at least 28 days after first dose #2 ____________________ Month Day Year

Polio

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACAP Web site for details)

1. OPV alone (oral Sabin three doses) #1 ____________ Month Day Year #2 ____________ Month Day Year #3 ____________ Month Day Year
2. IPV/OPV sequential IPV#1 ____________ Month Day Year IPV#2 ____________ Month Day Year IPV#3 ____________ Month Day Year IPV#4 ____________ Month Day Year
3. PIPV alone (injected Salk four doses) #1 ____________ Month Day Year #2 ____________ Month Day Year #3 ____________ Month Day Year #4 ____________ Month Day Year

* Varicella

(Birth in the U.S, before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes No or birth in U.S. before 1980 Yes No
2. Varicella antibody ____________ Month Day Year Result: Reactive Non-reactive
3. Immunization Dose #1 ____________ Month Day Year #2 ____________ Month Day Year given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age 13 years or older

* Tetanus-Diphtheria-Pertussis

(Primary series with DTaP, DTP, DT or Td and booster with Td or Tdap in the last ten years. Health sciences students with patient contact should receive one dose of Tdap at an interval as short as 2 years since last Td as appropriate. Refer to ACIP for details.)

1. Primary series of four doses with DTaP, DTP, DT of Td
   #1 ____________ Month Day Year #2 ____________ Month Day Year #3 ____________ Month Day Year #4 ____________ Month Day Year
2. Booster: Tdap (preferred) to replace a singe dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient.
   (Administer with MCV4 simultaneously if possible.) ____________ Month Day Year Booster: Td within the last ten years ____________. Month Day Year

Quadrivalent Human Papillomavirus Vaccine (HPV)

Dose #1 ____________ Month Day Year Dose #2 ____________ Month Day Year Dose #3 ____________ Month Day Year

Influenza

(Trivalent inactivated influenza vaccine or TIV. Live attenuated influenza vaccine or LAIV; licensed for healthy, nonpregnant persons ages 5-49 years old. Annual immunization recommended to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals. Health sciences students with patient contact.)

Date: TIV LAIV ____________________ TIV LAIV ____________________ TIV LAIV ____________________
Month Day Year Month Day Year Month Day Year

Hepatitis A

1. Immunization (Hepatitis A)

Dose #1 ____________________ Dose #2 ____________________
Month Day Year Month Day Year

2. Immunization (Combined Hepatitis A and B vaccine)

Dose #1 ____________________ Dose #2 ____________________ Dose #3 ____________________
Month Day Year Month Day Year Month Day Year

* Hepatitis B

(All college and health sciences students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (Hepatitis B)

Dose #1 ____________________ Dose #2 ____________________ Dose #3 ____________________
Month Day Year Month Day Year Month Day Year
Adult formulation Child formulation Adult formulation Child formulation Adult formulation Child formulation

2. Immunization (Combined hepatitis A and B vaccine)

Dose #1 ____________________ Dose #2 ____________________ Dose #3 ____________________
Month Day Year Month Day Year Month Day Year

3. Hepatitis B surface antibody

Date ____________________ Reactive Non-reactive
Month Day Year

Pneumococcal Polysaccharide Vaccine

(One dose for members of high-risk groups.)

Date ____________________
Month Day Year

Meningococcal Tetravalent

(A,C,Y,W-135/One dose - for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningocci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.)

Menactra *(preferred; data for revaccination pending; administer simultaneously with Tdap if possible):* Date ____________________
Month Day Year

Menomune *(acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues):*

Date ____________________ Date ____________________
Month Day Year Month Day Year

TUBERCULOSIS (TB) SCREENING FORM

Name ____
Last First Middle

Home Address ____
Street City State Zip Code

Telephone (home):___________________(cell):___________________Social Security Number: ___________________

Birth Date ________________ Birth Place: _________________________________Sex: ____________

To help us determine if you need to have a TB (Tuberculosis) skin test before coming to Salve Regina University, the following questions must be answered:

1. Are you non-US born, from a high prevalence country, including Africa, Asia, Philippines, Indonesia, Eastern Europe, Latin America, Mexico, Portugal, Caribbean, and the Middle East? **Yes** **No**
2. Have you lived or had extensive travel to a high prevalence country (listed above)? **Yes** **No**
3. Have you worked or lived in a potentially high risk setting such as a prison, a long term care facility, a homeless shelter, a residential facility for persons with HIV/AIDS or a drug treatment center? **Yes** **No**
4. Have you had recent close or prolonged contact with someone with infectious TB? **Yes** **No**
5. Do you or anyone living in your household have a history of intravenous or other street drug use, or HIV infection/AIDS? **Yes** **No**
6. Had BCG vaccine? **Yes** **No**
7. Have you ever had a documented positive TB skin test or history of active TB infection? **Yes** **No**

If you answered **No** to all of the above questions (1 – 7), no further testing or further action is required. Please sign below, and forward this form with your immunization record to Salve Regina University Health Services.

If you answered **Yes** to any of the first 6 questions and No to question 7, then you are required to have a PPD skin test or TB blood test (IGRA, TB Quantiferon Gold, TB-spot) within 6 months prior to the start of classes. The PPD skin test or IGRA must be performed in the U.S. Please have your provider document the results of your testing below. Sign the form and forward with your immunization record to Salve Regina University Health Services.

If you are **unable** to have either the PPD skin test or IGRA done in the US, you will need to have the testing performed at Salve Regina University Health Services within one month of starting at Salve Regina. There will be a charge for this service. **Forward** this form with your immunization record to Salve Regina University Health Services.

If you answered **Yes** to question 7, then you do not need to be retested, but must provide documentation of a negative chest x-ray done in the U.S (within 6 months prior to the start of classes), and documentation of any medication and treatment for your positive TB test. Please attach documentation to this form and forward with your immunization record to Salve Regina University Health Services.

TB (Tuberculin) Skin Test – must be performed in the U.S. (If you are unable to have the test done in the U.S., you will need a TB skin test at Salve Regina University Health Services within 1 month of starting at Salve Regina University. There will be a charge for this service.

Date TB skin test given: ____________________ Date TB skin test read (must be read in 48-72 hrs):________________

Results (**must be recorded in mm of induration; if no induration, write "0"**): ___________mm

IGRA must be performed in the U.S.: TB Quantiferon Gold ________ TB spot ________ Result: Positive Negative Indeterminate

Chest X-ray (Required if TB skin test is positive): Date: ________________ Result: Normal Abnormal

Dates of Treatment: ____

Signature of Physician / Medical Provider:____ Date:_______________

Physician / Medical Provider Name: (Please Print) / Clinic Stamp____

Address____

Phone number:______________________________ Fax Number:______________________________

By signing, I attest that the above information is true to the best of my knowledge.

Student Signature:____ Date:_____________________
Month Day Year

PHYSICAL EXAMINATION

Name ____

Last First Middle DOB

The physical examination, laboratory tests, and Mantoux test must be performed within eight months prior to registration.

System	Normal	Abnormal	Explanation of Abnormal Findings
Skin			
Ears			
Eyes			
Nose, throat, teeth			
Neck, thyroid			
Chest, breasts			
Lungs			
Heart			
Heart murmur			
Abdomen, liver, spleen, kidneys			
Hernia			
Genitalia			
Pelvic (if indicated)			
Rectal			
Lymphatic			
Extremities, back, spine			
Neurological			
Psychological			

Ht. ________ Wt. ________ BP ________ T ________ P ________ R ________

Urinalysis: Date __________ Sp. gr. ________ Sug. ________ Prot. ________ Mic. ________

Blood test: Date __________ Hgb. ________ Hct. ________ Cholesterol __________

Sports Clearance

The applicant may participate in sports

Without restriction

With the following restrictions: ______________________________

Should not participate in sports because ______________________________

Sickle Cell Screening (*Athletes Only*) Yes No (Attach Copy)

Is the examiner related to the student? Yes No If yes, please indicate relationship ______________

______________________________ M.D.
Physician's Signature

______________________________ M.D.
Print

____
Address

____

____
Telephone Number

____
Date of examination

Mail completed form to:

University Health Services
SALVE REGINA UNIVERSITY
100 Ochre Point Ave.
Newport, RI 02840-4192

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