

University Health Service
MEDICAL RECORD



■ PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE COMPLETING THIS FORM

IMPORTANT: Legal safeguards make it necessary for each student to have a medical, physical and immunization record on file in the University Health Service. The primary purpose of this medical record is to provide a basic point of reference in case of future illness, to identify any medical condition requiring attention before it interferes with your studies, and to provide the University Health Service staff with knowledge of any necessity for ongoing treatment. All information revealed will be strictly confidential. The University Health Service is HIPAA compliant.

STUDENTS: This form must be completed, returned and verified by University Health Service personnel by Aug. 5. Satisfactory completion of this process is required before you can receive your housing information.

SEND FORMS TO
University Health Service
The University of the South
SPO Box 1182
Sewanee TN 37383-1000

FOR INFORMATION
Call 931.598.1270

Student's Name: _____

Date of birth: _____ Social Security Number _____

Street address: _____ City _____ State/Zip _____

Parents, guardian, or spouse name(s): _____

Home phone: (_____) _____

Mother's work phone: (_____) _____ Father's work phone: (_____) _____

In case of emergency, notify: _____

Relationship to you (*mandatory*): _____ Home phone: (_____) _____

Work phone: (_____) _____ Cell phone: (_____) _____

Student cell phone number: (_____) _____

INSURANCE

All students are required to have adequate health insurance that will provide coverage while in the Sewanee area. It is the responsibility of the student and/or parent to ensure that there are no restrictions or limitations with your insurance coverage should medical care be necessary.

A copy of the student's insurance card, front and back, must be included with this form. In addition, please refer to <http://www2.sewanee.edu/sewaneescene/forms/inspolicy> for information regarding the health insurance requirements and instructions on how to submit the insurance waiver. **This insurance waiver must be submitted online; paper forms cannot be accepted.** The URL address for the waiver is <https://studentcenter.uhcsr.com/sewanee> and will be accessible from July 1 to Aug. 30, 2011.

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I hereby authorize the staff of the University Health Service, their agents or consultants to perform diagnostic and treatment procedures, which in their judgment may become necessary while the student is enrolled at The University of the South.

Student signature: _____ Date (mm/dd/yr): _____

Parent/guardian signature: _____ Date (mm/dd/yr): _____

University Health Service

HEALTH CARE PROVIDER'S REPORT & FAMILY MEDICAL HISTORY



Student's Name: _____ Date of birth: _____ SS# _____

Home address: _____

To the student: please complete the other side of this form before taking it to your health care provider.

HEALTH CARE PROVIDER'S REPORT OF PHYSICAL EXAMINATION

To the examining health care provider: Please review the student's history (on the back of this form) and complete the provider's form below, as well as the student's immunization record. Please comment on all positive answers. This student has been accepted — the information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for use of the University Health Service and will not be released without student consent.

Laboratory data (required for all students)

Height _____ Weight _____ B/P _____ Pulse _____

Visual acuity: uncorrected _____ corrected _____ Circle one: glasses contact lens both

HCP Evaluation

Date of examination _____ Name of provider (please print) _____

Physical examination is within normal limits: ___ Yes ___ No If abnormal, please explain and attach a copy of your report:

Have you treated this student for any significant disease or medical problem other than minor short term illness? ___ Yes ___ No

If so, please explain _____

Is this student currently under your care and on medication? ___ Yes ___ No If so, please explain _____

Does this student have drug allergies? ___ Yes ___ No If yes, please list _____

How can we be of assistance to you in the care of your patient? Attach a copy of evaluation and recommendations, or explain _____

Do you consider this student physically and emotionally capable of handling college academics/life? ___ Yes ___ No ___ Doubtful

If "no" or "doubtful," please give reasons _____

In your opinion is he/she physically qualified for: (please circle) unrestricted restricted athletics, exercise or walking?

If restricted, list basis for restriction _____

Is restriction permanent? ___ Yes ___ No or temporary? ___ Yes ___ No If temporary, for how long? _____

Does the student have any food allergies? ___ Yes ___ No If yes, please list _____

Is the student on a special diet or have other dietary restrictions? ___ Yes ___ No If yes, please explain _____

Signature of examining health care provider _____

Phone (_____) _____ Fax (_____) _____

Address _____

City _____ State/Zip _____

Student's Name: _____ Date of birth: _____ SS# _____

FAMILY MEDICAL HISTORY

	Age	Occupation	State of health	If deceased, age at death	Cause of death
Father					
Mother					
Brothers					
Sisters					

List family history and relationship to you of any disease such as diabetes, hypertension, heart disease, cancer, etc.: _____

HEALTH HISTORY

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Chicken pox (Year?)	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney stone	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Drug/alcohol problem	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	Back problems	<input type="checkbox"/>	Eating disorder	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	Thyroid problem
<input type="checkbox"/>	Blood disorder/anemia	<input type="checkbox"/>	Eye injury or disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bone/joint problems	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	Neurological disorder	<input type="checkbox"/>	Ulcer — stomach or duodenal
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Urinary infection/problems
<input type="checkbox"/>	Cardiac problem	<input type="checkbox"/>	Hepatitis (jaundice)	<input type="checkbox"/>	Recurrent bronchitis	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chest pain/shortness of breath	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Recurrent sinusitis	<input type="checkbox"/>	

Females only							
<input type="checkbox"/>	Abnormal pap smear	<input type="checkbox"/>	Breast mass	<input type="checkbox"/>	Female surgery		
<input type="checkbox"/>	Irregular periods	<input type="checkbox"/>	Severe cramps	Are you on medication for cramps or regulation of periods? ___ Yes ___ No If so, name: _____			

Explain conditions checked: _____

Are you currently taking any medications? ___ Yes ___ No If so, list names: _____

Do you have any drug allergies? ___ Yes ___ No If so, name drug: _____

Do you have any other allergies? ___ Yes ___ No If so, explain: _____

Have you ever been admitted to a hospital? ___ Yes ___ No If so, please give date and reason for admission: _____

Do you have any physical challenges or conditions that may impact your activity? ___ Yes ___ No If so, explain: _____

Have you ever had treatment for nervous or emotional problems? ___ Yes ___ No If so, explain: _____

By whom were you treated? _____ Address: _____

If medication used for treatment, name: _____

Have you ever been treated for an eating disorder? ___ Yes ___ No If so, explain: _____

MENTAL HEALTH HISTORY

Do you have, or have you experienced, any of the following:

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Family alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Recent death of a loved one
<input type="checkbox"/>	<input type="checkbox"/>	Drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of sadness or loneliness
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of depression
<input type="checkbox"/>	<input type="checkbox"/>	Rape or sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping
<input type="checkbox"/>	<input type="checkbox"/>	Dating or domestic violence	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty controlling temper

IMMUNIZATION RECORD PART I

Student's Name: _____ Date of birth: _____ SS# _____

TUBERCULOSIS (TB) SCREENING/TESTING¹

Have you ever had a positive TB skin test? ___ Yes ___ No

Have you ever had close contact with anyone who was sick with TB? ___ Yes ___ No

Were you born in one of the countries listed below and arrived in the U.S. within the past five years? ___ Yes ___ No

(If yes, please circle ○ the country.)

Have you ever traveled* to/in one or more of the countries listed below? ___ Yes ___ No

(If yes, please check ✓ the country/ies.)

Have you ever been vaccinated with BCG? ___ Yes ___ No

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Afghanistan	Cook Islands	Japan	Nicaragua	Sudan
Algeria	Côte d'Ivoire	Kazakhstan	Niger	Suriname
Angola	Croatia	Kenya	Nigeria	Swaziland
Argentina	Democratic People's	Kiribati	Pakistan	Syrian Arab Republic
Armenia	Republic of Korea	Kuwait	Palau	Tajikistan
Azerbaijan	Democratic Republic	Kyrgyzstan	Panama	Thailand
Bahrain	of the Congo	Lao People's Democratic	Papua New Guinea	The former Yugoslav
Bangladesh	Djibouti	Republic	Paraguay	Republic of Macedonia
Belarus	Dominican Republic	Latvia	Peru	Timor-Leste
Belize	Ecuador	Lesotho	Philippines	Togo
Benin	El Salvador	Liberia	Poland	Tonga
Bhutan	Equatorial Guinea	Libyan Arab Jamahiriya	Portugal	Trinidad and Tobago
Bolivia (Plurinational	Eritrea	Lithuania	Qatar	Tunisia
State of)	Estonia	Madagascar	Republic of Korea	Turkey
Bosnia and Herzegovina	Ethiopia	Malawi	Republic of Moldova	Turkmenistan
Botswana	French Polynesia	Malaysia	Romania	Tuvalu
Brazil	Gabon	Maldives	Russian Federation	Uganda
Brunei Darussalam	Gambia	Mali	Rwanda	Ukraine
Bulgaria	Georgia	Marshall Islands	Saint Vincent and	United Republic of Tanzania
Burkina Faso	Ghana	Mauritania	the Grenadines	Uruguay
Burundi	Guam	Mauritius	Sao Tome and Principe	Uzbekistan
Cambodia	Guatemala	Micronesia (Federated	Senegal	Vanuatu
Cameroon	Guinea	States of)	Serbia	Venezuela (Bolivarian
Cape Verde	Guinea-Bissau	Mongolia	Seychelles	Republic of)
Central African Republic	Guyana	Montenegro	Sierra Leone	Viet Nam
Chad	Haiti	Morocco	Singapore	Yemen
China	Honduras	Mozambique	Solomon Islands	Zambia
Colombia	India	Myanmar	Somalia	Zimbabwe
Comoros	Indonesia	Namibia	South Africa	
Congo	Iraq	Nepal	Sri Lanka	

Source: World Health Organization

IF THE ANSWER IS YES TO ANY OF THE ABOVE QUESTIONS, The University of the South requires that a health care provider complete the **tuberculosis risk assessment** (to be completed within six months prior to the start of classes).

IF THE ANSWER TO ALL OF THE ABOVE QUESTIONS IS NO, no further testing or further action is required.

1. The American College Health Association has published guidelines on "Tuberculosis Screening and Targeted Testing of College and University Students." To obtain the guidelines, visit <http://www.acha.org>.

IMMUNIZATION RECORD PART II

Student's Name: _____ Date of birth: _____ SS# _____

TUBERCULOSIS (TB) RISK ASSESSMENT

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Recent close contact with someone with infectious TB disease: ___ Yes ___ No

Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America): ___ Yes ___ No

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease: ___ Yes ___ No

HIV/AIDS: ___ Yes ___ No

Organ transplant recipient: ___ Yes ___ No

Immunosuppressed (equivalent of >15 mg/day of prednisone for >1 month or TNF-α antagonist): ___ Yes ___ No

History of illicit drug use: ___ Yes ___ No

Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities): ___ Yes ___ No

Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]: ___ Yes ___ No

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

1. Does the student have signs or symptoms of active tuberculosis disease? ___ Yes ___ No

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0." The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ___/___/___ Date Read: ___/___/___ Result: ___ mm of induration **Interpretation: positive___ negative___

Date Given: ___/___/___ Date Read: ___/___/___ Result: ___ mm of induration **Interpretation: positive___ negative___

3. Interferon Gamma Release Array (IGRA)

Date Obtained: ___/___/___ Specify method: ___ QFT-G ___ QFT-GIT ___ T-Spot Other: _____

Result: ___ negative ___ positive ___ indeterminate ___ borderline (T-Spot only)

Date Obtained: ___/___/___ Specify method: ___ QFT-G ___ QFT-GIT ___ T-Spot Other: _____

Result: ___ negative ___ positive ___ indeterminate ___ borderline (T-Spot only)

4. Chest x-ray (Required if TST or IGRA is positive.)

Date of chest x-ray: ___/___/___ Result: ___ normal ___ abnormal

**Interpretation guidelines:

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
Organ transplant recipients
Immunosuppressed persons: taking >15 mg/d of prednisone for >1 month; taking a TNF-α antagonist
Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
History of illicit drug use
Mycobacteriology laboratory personnel
History of resident, worker, or volunteer in high-risk congregate settings
Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

*The significance of the exposure should be discussed with a health care provider and evaluated.

Healthcare Provider Name: _____ Signature _____

Address: _____ Phone (_____) _____

University Health Service

IMMUNIZATION RECORD PART III

Student's Name: _____ Date of birth: _____ SS# _____

Required immunizations

MMR (measles, mumps, rubella) — two doses required

- 1. Dose 1 (at age 12 mos. or later) M/D/Y
2. Dose 2 (at least 28 days after first dose) M/D/Y

Tetanus, diphtheria, pertussis — tetanus/diphtheria (Td) OR tetanus/diphtheria/pertussis (Tdap) must be within the last ten years. Tdap booster recommended for ages 11-64 unless contraindicated.

- 1. Date of most recent dose: M/D/Y Type of booster: ___ Tdap ___ Td

Polio — if all dates of primary series not known, three primary series are acceptable.

- 1. OPV alone (oral Sabin in three doses). 1 M/D/Y 2 M/D/Y 3 M/D/Y
2. IPV/OPV sequential. 1 M/D/Y 2 M/D/Y 3 M/D/Y 4 M/D/Y
3. IPV alone (injected Salk, four doses). 1 M/D/Y 2 M/D/Y 3 M/D/Y 4 M/D/Y

Varicella — history of chicken pox, a positive varicella antibody, or two doses of vaccine (if given after age 13) meets the requirement.

- 1. History of disease ___ Yes ___ No Date of disease M/D/Y
2. Varicella antibody M/D/Y Result: ___ reactive ___ non-reactive
3. Immunization date Dose 1 M/D/Y
Dose 2 (given at least 12 weeks after first dose ages 1-12 and at least 4 weeks after first dose if age 13 years or older) M/D/Y

Hepatitis B — three doses of Hepatitis B OR three doses of Hepatitis A/B vaccine meet the requirement.

- 1. Hepatitis B Dose 1 M/D/Y Dose 2 M/D/Y Dose 3 M/D/Y
2. Hepatitis A & B combined Dose 1 M/D/Y Dose 2 M/D/Y Dose 3 M/D/Y

Meningococcal (A, C, Y, W-135) — One or two doses for all college students; revaccinate every five years in increased risk continues.

- 1. Menactra — preferred) M/D/Y
2. Menomune M/D/Y

Recommended immunizations

Quadrivalent human papilloma virus vaccine (HPV) Gardasil — Three doses of vaccine for female students 11-26 years of age and males 9-26 years of age.

- Dose 1 M/D/Y Dose 2 M/D/Y Dose 3 M/D/Y

Hepatitis A — two doses of Hepatitis A OR two doses of Hepatitis A/B vaccine.

- 1. Hepatitis A Dose 1 M/D/Y Dose 2 M/D/Y
2. Hepatitis A & B combined Dose 1 M/D/Y Dose 2 M/D/Y

Health care provider signature _____ Name (print) _____

Address _____ City _____ State/Zip _____

Phone (_____) _____ Fax (_____) _____