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 June 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

ATTACH PHOTO

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, over the counter medications 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 Conjugate (MCV4) – Mandatory

A. One (1) dose of meningococcal conjugate (MCV4) vaccine required for unvaccinated full time undergraduate and graduate students (under 22) who live in a dormitory or comparable living arrangement.

B. Evidence of a second (booster dose) of MCV4 vaccine is required for students (under 22) if the first dose was given before 16 years of age.

:

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 annual examination, laboratory tests, and Mantoux test must be performed within 12 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

SALVE REGINA UNIVERSITY