Student Health Form

Class of 2021

Please submit completed form by July 15, 2017

Health & Wellness
Transylvania University
300 N. Broadway
Lexington, KY 40508

FAX: (859)233-8101
Email: HealthForms@transy.edu

All students are required to complete this health form. **Students who do not submit all required information will not be allowed to utilize health services on campus. All information is confidential and for Health and Wellness use only.**

Last Name:_____ First Name:_____ Preferred Name:_____

Birth Gender: ☐ Female ☐ Male Gender Identity: ☐ Female ☐ Male

Birthdate: Month:_____ Day:_____ Year:_____

Name of Parent(s) or Guardian(s):_____

Who should we call in an emergency? Name:_____ Phone ( )_____

Name:_____ Phone ( )_____

Medical History

Are you allergic to any medications, foods, latex, insect stings? ☐ No ☐ Yes

If yes, please list:_____

Do you carry an Epi-Pen? ☐ No ☐Yes

*If you carry an Epi-Pen, please register with Disability Services. If you have a food allergy, please consider notifying the Manager of Dining Services.

Do you take any medications (including contraceptives) on a regular basis? ☐ No ☐ Yes

If yes, please list:

_____

_____

Do you currently have any conditions that require medical treatment? (i.e. diabetes, heart condition, asthma, ADD/ADHD, anxiety or depression) ☐ No ☐ Yes

If yes, please list:

_____

_____

Please list any past surgeries, major injuries or traumas, or hospitalizations:

_____

Do you have any special needs with which Student Health Services, the Counseling Center or Disability Services can assist you with or that may require follow up? ☐ No ☐ Yes

If yes, please explain:

_____

_____

Is there anything else you would like us to know about your physical or mental health needs?

_____

Last Name:_____ Birth Date:_____

Physical Exam: Recommended but not required.

BP:_____/_____	Pulse:	Height:	Weight:	BMI:

	Normal	Abnormal		Normal	Abnormal
General Appearance			Heart		
HEENT			Lungs		
Neck			Abdomen		
Skin			Musculoskeletal		
Neuro/Psych			Male GU (include hernia & testicular exam)		
Comment on any ***ABNORMAL*** findings:					

IS THIS PERSON CURRENTLY UNDER TREATMENT FOR ANY MEDICAL, EMOTIONAL, OR PSYCHIATRIC CONDITION(S)?

☐ No ☐ Yes-Specify:

Health Care Provider Signature:_____ Date:_____

Required Tuberculosis Screening-Tuberculosis (Tb) Screening is required, primarily by conducting a risk assessment. If you answer "YES" to any of the questions below, a Tb skin test, a IGRA blood test(TSpot or QuantiferonGold) must be completed prior to your arrival on campus.The test should be administered no sooner than 9 weeks after traveling to or working in a high Tb risk setting.

1.	Have you ever had a positive test or treatment for Tb?	☐ No ☐ Yes
2.	Have you ever had close contact with persons known or suspected to have active TB disease?	☐ No ☐ Yes
3.	Do you have any of the following signs or symptoms of active Tb? ● Productive cough for >3 weeks, &/or bloody sputum ● Unexplained weight loss. ● Night Sweats or fevers.	☐ No ☐ Yes
4.	Have you been a member of any of the following high risk groups? ● Have HIV infection. ● Inject drugs ● Resident, employee or volunteer in a high-risk congregate setting (i.e. hospital, nursing home, homeless shelter, correctional facility) ● Have a clinical conditions such as diabetes, leukemia, lymphoma, chronic malabsorption, renal failure, long term corticosteroid use,or any other immunosuppressive condition or medication use.	☐ No ☐ Yes
5.	Have you lived or had frequent or prolonged visits to a country where Tb is endemic in the past 5 years (most countries in Latin America, the Caribbean, Africa, Asia, Eastern Europe, and Russia)?	☐ No ☐Yes

*****Please Note:** If you answered NO to all, then no further testing is required.You must only see your medical provider for a test indicated below **IF** you answered YES to any of the questions above.

Medical Provider: If further testing required**,** use the space below to document Tb testing or attach proof of results.

Tb Skin Test	Date:	Date Read:	____mm induration	● ☐Positive ☐ Negative Based on CDC classifications
IGRA Blood Test T--Spot or Quantiferon	Date:	☐Positive ☐ Negative ☐ Intermediate	If applicable: Was INH Initiated? ☐ No ☐ Yes If yes, when?_____ Was INH completed? ☐ No ☐Yes	
Chest X-Ray (If TST or IGRA positive)	Date:	☐Normal ☐Abnormal		

_____ _____

Provider's Signature Date

Last Name:_____ Birth Date:_____

Required Immunizations- Transylvania University has the following prematriculation vaccination requirements and recommendations, derived from guidelines issued by the American College Health Association (ACHA), the Centers for Disease Control & Prevention (CDC), and the Federal Advisory Committee on Immunization Practices (ACIP).

Required Vaccines:	**Recommended Vaccines:**
• Tetanus, Diphtheria, & Pertussis (Tdap) within the last 10 years • Two Measles, Mumps, & Rubella (MMR) vaccines or proof of immunity. • Meningitis Conjugate (Menactra or Menveo) Vaccine on or after 16th birthday	• Varicella (chicken pox) or proof of immunity • Hepatitis A & B • HPV • Annual Influenza **Optional:** • Serogroup B Meningococcal Vaccine (Trumenba or Boxsera)

Vaccination Records must be submitted prior to arrival on campus. Please attach proof of immunizations (signed state or school vaccination form) or have a provider complete below:

MMR (Measles, Mumps, Rubella)	Dose 1:_____ Dose 2:_____ Or Titer:_____	Dose 1 must be after 12 months of age,. Dose 2 must be at least 1 month after dose 1.	
Tdap Tetanus, Diphtheria, Pertussis	Date:_____	Must be administered within the last 10 years.	_____ Provider Signature
Meningococcal Conjugate	Date:_____	Must be administered on or after 16th birthday	_____ Date
Serogroup B Meningococcal Vaccine (Trumenba or Boxsera) **optional**	Date:_____		

State of Kentucky law requires all postsecondary educational institutions with residential campuses provide vaccination information on meningococcal meningitis and Hepatitis B to students living in residential housing. To help us comply with this regulation, please read the following statements and sign below:

Have you received 1 dose of Menactra or Menveo (MCV4)? ☐ Yes ☐ No
Have you received Hepatitis B vaccine series? ☐ Yes ☐ No

Meningitis is a rare but serious inflammation of the lining that surrounds the brain and spinal cord. College freshman who live in residence halls have a modestly increased risk of meningococcal disease relative to other persons their age. The most common early signs are similar to the flu- high fever, severe headache, neck stiffness, nausea & vomiting, lethargy & rash. It is transmitted through close, direct contact with the oral secretions of an infected person, such as kissing, sharing drinks or utensils, or coughing. Students are urged to seek medical care immediately of the experience two or more of these symptoms concurrently. Meningtis Vaccines (i.e.Menactra or Menveo) is a relatively safe vaccine that can protect against four of the five most common strains of the bacteria that causes meningitis. Protective antibody levels are achieved 7-10 days after vaccine administration, and provides protection for about 5 years. The National Centers for Disease Control(CDC) and the American College Health Association (ACHA) recommend all college students receive the vaccine or booster on or after 16th birthday. For more information: http://www.cdc.gov/meningitis/

Hepatitis B is a viral infection of the liver that can cause permanent liver damage, liver cancer and even death. It is transmitted directly through contact with blood & body fluids or indirectly through objects contaminated by blood or body fluids. Common modes of transmission include sexual contact, needle sharing, piercings or tattooing, or sharing of razors or toothbrushes.Signs & symptoms can include, yellowing of the eyes & skin, fever, abdominal, nausea, vomiting, and dark colored urine. The Hepatitis B Vaccine Series (3 injections given over 6 months) is a safe & effective measure to prevent Hepatitis B. The CDC & ACHA strongly recommend all college students be vaccinated against Hepatitis B. For more information:http://www.cdc.gov/vaccines/vpd-vac/hepb/default.htm

_____ _____

Student (or parent if student is under 18 years of age) Date

Last Name:_____ Birth Date:_____

Authorization to Treat

My signature below indicates that:

- I authorize and consent to the examination and/or treatment by Transylvania University Health & Wellness clinicians.
- I understand that in emergency situations this may also serve as consent to treat at any medical, surgical, or psychiatric facility deemed necessary.
- I understand that there is no fee for office visits; however, student accounts can be billed, at minimal cost, for point of care testing (i.e. strep, flu, mono, and Tb skin test), and immunizations. Additional laboratory or radiology testing will be referred to a local facility that will bill insurance.

Medical Records/Privacy

Transylvania University Health & Wellness is committed to protecting the security and privacy of your personal information and medical records. Medical records are the property of Transylvania University Student Health. They will be kept in a secure location on site, or uploaded and maintained in an electronic medical record that is also secure. Medical records are accessed only for purposes outlined in the ***Health Services Commitment to Privacy & Confidentiality***. Medical records are separate from academic records.

My signature below indicates that:

- I have read the Health Services "Commitment to Privacy & Confidentiality"
- I understand that my health information & medical records will be confidential and separate from my academic records.
- I understand that Transylvania University clinical, sports medicine, counseling & disabilities services may, on occasion, share pertinent health information to provide integrated care for me.
- I understand that there may be times when confidential information may be shared with appropriate Transylvania University services or outside medical providers or facilities to coordinate care or in emergency situations.
- I authorize Transylvania University Health Services to obtain health information from another medical facility as it pertains to my care.
- I understand that Transylvania University is required by law to report positive results of certain laboratory tests to the Kentucky Department of Health.
- I understand that email is not a secure form of communication, and if I choose to communicate with health care clinician via email, privacy is not ensured.

This authorization shall expire at date of graduation or permanent withdrawal from Transylvania University. A copy is as valid as the original.
I understand that I may amend, change, or cancel this agreement at any time by written notice to Transylvania Health & Wellness.

I further attest that the information provided by me, on this form, has been truthfully completed to the best of my knowledge.

I understand and agree to all of the above unless I strike through & initial any of the statements.

_____ _____

Signature of Student Date

_____ _____

Signature of parent or guardian (if student <18) Date

**** Health Insurance: All Students are required to provide proof of health insurance. Please attach a copy of both sides of your insurance card.**

Insurance Provider_____ Member ID_____ Group#_____

Students with Disabilities:

If you believe you will need accommodations for a disability or medical condition that qualifies under the provisions of the Americans with Disabilities Act, please submit documentation from your healthcare provider (i.e. Physician, Physician Assistant, Nurse Practitioner, Psychiatrist, Psychologist) by **June 1**. More information, including the application form, can be found here:http://www.transy.edu/campus/disability-accommodations

Note to Athletes:

If you are planning to participate in Intercollegiate Sports, you must also complete Athletic Training Paperwork.
Specific Instructions for Intercollegiate Athletes can be found at:
http://www.transysports.com/information/transylvania_sports_medicine