

# STUDENT HEALTH RECORD

STUDENT HEALTH CENTER

(401) 865-2422

FAX (401) 865-2809



PROVIDENCE  
COLLEGE

BANNER ID# \_\_\_\_\_

P.C. GRADUATION YR: \_\_\_\_\_

CELL PHONE \_\_\_\_\_

HOME PHONE \_\_\_\_\_

## PERSONAL AND CONFIDENTIAL

PLEASE PRINT OR TYPE

Name: \_\_\_\_\_ Male  Female   
Last First MI

Home Address: \_\_\_\_\_  
Street City State Zip

Place of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Mother's cell/work: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Father's cell/work: \_\_\_\_\_

## PERSONS TO BE NOTIFIED IN THE EVENT OF AN EMERGENCY:

1 \_\_\_\_\_  
Name Address Telephone Relationship

2 \_\_\_\_\_  
Name Address Telephone Relationship

## AUTHORIZATION FOR TREATMENT:

*I hereby authorize the Providence College Student Health Center to hospitalize and/or provide medical treatment and services as it deems appropriate. This authorization will remain in effect as long as I am a student at Providence College.*

Student signature \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date: \_\_\_\_\_  
(For students under 18 years of age)

## ALLERGY INFORMATION (PLEASE LIST ALL)

Do you require the use of an epi-pen? YES  NO  If yes, please carry it with you.

Medicine Allergy: \_\_\_\_\_

Environmental Allergy: \_\_\_\_\_

Food Allergy: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Are you presently on medication? YES  NO  If yes, please explain below.

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

Name: \_\_\_\_\_ Dosage: \_\_\_\_\_

## HEALTH INSURANCE COVERAGE (PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR INSURANCE CARD TO THIS FORM.)

Address and telephone number must be included. It is the responsibility of each student to understand the requirements of his/her medical coverage.

1. Does your insurance coverage require pre-authorization?  YES  NO

2. Does your insurance company cover you in the State of Rhode Island?  YES  NO

Name of Insurance: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Address of Insurance: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name of principal insured: \_\_\_\_\_

Employment of principal insured: \_\_\_\_\_

**Services are available only to those students who have this completed form on file in the Student Health Center.**

**\*This form must be returned to the Student Health Center by July 17, 2009.\***

**FAMILY HISTORY**

	AGE	CURRENT HEALTH STATUS	IF DECEASED AGE	CAUSE
Father				
Mother				
Siblings				

Please answer the following questions relating to your past and present medical history. Whenever in doubt, clarify this history with your parents and/or provider.

**HOSPITALIZATION/ SURGERY**

Have you ever been hospitalized or had surgery?

YES  NO

If yes, please explain below.

HOSPITAL

REASON

DATE

**PERSONAL HISTORY:**

	YES	NO		YES	NO		YES	NO
Anemia			Fractured Bones			Pleurisy		
Arthritis			Gastrointestinal Disorder			Pneumonia		
Asthma			Gyn Exam			Polio		
Back Problems			Head Injury			Psychiatric Illness/ Evaluation		
Blood Disease			Headaches (frequent)			Rheumatic Fever		
Colitis			Hearing Loss			Seizure Disorder (Epilepsy)		
Counseling			Heart Disease/ Murmur			Skin Disease		
Crohn's Disease			Hernia			Substance Misuse		
Deformities of Bones/ Joints			Hypertension			Thorax and Breasts		
Dental			Jaundice			Thyroid Disease		
Diabetes			Kidney Disease			Tropical Disease or Parasites		
Ear Infections (recurrent)			Liver Disease			Tuberculosis		
Eating Disorders: Anorexia			Lung Disease			Ulcer Disease		
Bulimia			Lyme Disease			Urinary Tract Infections		
Endocrine Disease			Mononucleosis Date: / /			Viral Hepatitis		
Eye, Ear, Nose, Throat Disorder			Muscular Disease			Visual Impairment		
Fainting (frequent)			Neurological Disease			Weight Loss or Gain		
						Other		

**TUBERCULOSIS -SCREENING**

1. Do you have signs or symptoms of active TB? (e.g. fever, cough, night sweats)

YES  NO

If NO, proceed to question 2.

If YES, proceed with additional evaluation to exclude active TB disease including Tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Are you a member of a high-risk group or entering a health profession?

YES  NO

If NO, stop. No further evaluation is needed at this time.

If YES, you will need to have a Tuberculin skin test.

**HIGH-RISK**

Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low, rather than high, TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries except those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samos, Australia, or New Zealand.

Other categories of high-risk students include those with HIV infection; who inject drugs; who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone > 15mg/d for > 1 month) or other immuno-suppressive disorders.

The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit [www.acha.org](http://www.acha.org) or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or the following Web site [www.cdc.gov/nchstp/tb/pubs/corecurr/](http://www.cdc.gov/nchstp/tb/pubs/corecurr/)

**FOR YOUR PROVIDER** Please review patient's personal history and TB screening before completing physical exam. Please date and sign below.

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Vision: DISTANCE R \_\_\_\_\_ L \_\_\_\_\_ BOTH \_\_\_\_\_

CORRECTED  NOT CORRECTED

GLASSES  CONTACTS

	NORMAL	ABNORMAL
HEENT		
NODES		
CV		
RESP		
ABD		

	NORMAL	ABNORMAL
BACK		
MS		
NEURO		
SKIN		
GU/ GYN		

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_

**SUMMARY OF EXAMINING PROVIDER**

Is this student receiving or does he/she require continuing medical care, therapy, or observation?

YES  NO

If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

On the basis of the foregoing Medical History and Physical Examination, should restrictions be imposed on physical activity?

YES  NO

If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

From the standpoint of physical and mental health, do you have any reservations about the advisability of this individual's plans for his/her college years?

YES  NO

If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

Does the individual have any physical disabilities that we should be aware of and that may require assistance through the Student Health Center?

YES  NO

If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

Does the individual have any psychological or physical conditions which would necessitate a special diet or nutritional accommodations?

YES  NO

If yes, please explain:

\_\_\_\_\_  
 \_\_\_\_\_

Please include notation of medication (and dosages) and investigative reports concerning pre-existing illnesses such as heart disease, asthma, diabetes, seizure disorders, etc.

\_\_\_\_\_  
 \_\_\_\_\_

**PROVIDER'S SIGNATURE, CONTACT INFORMATION AND DATE OF EXAM REQUIRED**

\_\_\_\_\_  
 Provider (Please print)

\_\_\_\_\_  
 Provider's signature required

\_\_\_\_\_  
 Address (Please print)

\_\_\_\_\_  
 Telephone number

\_\_\_\_\_  
 City, State, Zip (Please print)

\_\_\_\_\_  
 Fax number

\_\_\_\_\_  
 Date of exam

**IMMUNIZATION RECORD:** This form is to be completed by your provider or attach valid proof of immunizations. Acceptable evidence must include day, month, year and type/name of each dose of vaccine administered. Immunity is required prior to registration.

**A) TETANUS-DIPHTHERIA - Required within the past 10 years.**

Td  Tdap   
Date (mm/dd/yy) \_\_\_\_\_

**B) M.M.R. (Measles, Mumps, Rubella) - Two doses are required**

Dose 1- Required on or after first birthday. Date (mm/dd/yy) \_\_\_\_\_  
Dose 2- Required Date (mm/dd/yy) \_\_\_\_\_

**C) POLIO**

Completed primary series of polio immunization. YES  NO   
Type of vaccine: ORAL  IPV   
Last booster:  Date (mm/dd/yy) \_\_\_\_\_

**D) VARICELLA (Chicken Pox) - Required**

Had disease  Date (mm/dd/yy) \_\_\_\_\_  
or  
Vaccinated Dose 1:  Date (mm/dd/yy) \_\_\_\_\_  
\*Dose 2:  Date (mm/dd/yy) \_\_\_\_\_

\*2nd Varicella vaccine is required if 1st dose was administered on or after 13th birthday\*

**E) HEPATITIS B SERIES - Required**

Dose 1:  Date (mm/dd/yy) \_\_\_\_\_  
Dose 2:  Date (mm/dd/yy) \_\_\_\_\_  
Dose 3:  Date (mm/dd/yy) \_\_\_\_\_

**F) MENINGOCOCCAL VACCINE - (*Highly recommended*)**

Date (mm/dd/yy) \_\_\_\_\_

**G) TUBERCULIN SKIN TEST - Required** only for those students reporting to be in a high-risk category or entering a health profession. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

Administered:  Date (mm/dd/yy) \_\_\_\_\_  
Read:  Date (mm/dd/yy) \_\_\_\_\_

Record actual mm of transverse diameter. If no induration, write "O". \_\_\_\_\_ mm

Interpretation based on mm of induration as well as risk factors. Positive  Negative

CHEST X-RAY - Required if Tuberculin skin test is positive. Positive  Negative

X-RAY Date (mm/dd/yy) \_\_\_\_\_

This health form including immunization record must be received by Student Health prior to July 17, 2009.

PLEASE MAIL OR FAX TO:

Student Health Center  
Providence College  
1 Cunningham Square  
Providence, RI 02918-0001  
Fax: (401) 865-2809