

STUDENT HEALTH RECORD

STUDENT HEALTH CENTER

(401) 865-2422

FAX (401) 865-2809

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 21, 2008. ***

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 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/

PROVIDENCE COLLEGE STUDENT HEALTH RECORD NAME: _____ DOB _____

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 _____ Date (mm/dd/yy)
 Dose 2- Required _____ Date (mm/dd/yy)

C) POLIO

Completed primary series of polio immuniz: 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 D 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 "0". _____ 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 21, 2008.

PLEASE MAIL OR FAX TO:
 Student Health Center
 Providence College
 549 River Avenue
 Providence, RI 02918-0001
 Fax: (401) 865-2809