

Delaware State University Student Health Form



All residential students, all full-time undergraduate commuter students and all international F-1 status students are required to complete a Student Health Form. Please complete this form in black or blue ink.

Note: Failure to submit your completed student health form will affect your access to class registration and campus housing.

- 1.** Mail this completed Health Form packet to:
Delaware State University
Campus Health Center
1200 North DuPont Highway, Dover, DE 19901

*Emailed and faxed copies will not be accepted.

Due Dates

Fall Semester: July 15

Spring Semester: December 1

- 2.** Complete medical history questionnaire electronically by visiting **desu.studenthealthportal.com**.

Section 1: Your Personal Information, Signed Consent and Acknowledgment

Last	First	Middle Initial
Street Address	City	State
ZIP	DSU Email Address	Student Telephone Number
Delaware State University Student ID Number	Semester Entering: ☐ Fall ☐ Spring ☐ Summer Academy	Year
Date of Birth	Gender Identity	
Boarder: ☐ Check here if you plan to stay in campus housing	Status: (Select all that apply)	
Commuter: ☐ Check here if you plan to live off campus	☐ Full-time ☐ Part-time ☐ Graduate ☐ Undergraduate ☐ Collegiate Athlete ☐ International Student	
Emergency Contact Information:		
Last	First	Telephone/Cell Number

***If you will be under age 18 at the time of enrollment,** it is very important that Campus Health Services have permission from either your parents(s) or guardian(s) to provide medical care until your 18th birthday. Please have one or both of them sign the following consent form:

I hereby grant permission to Campus Health Services of Delaware State University to render medical care to my dependent _____.

Signed

Date

Your signature indicates permission for Campus Health Services to obtain urgent and emergency care if you are not available. This care may be provided at the hospital and any other health care institution in the area.

CHECKLIST TO CONFIRM A COMPLETED HEALTH FORM

- ☐ Completed online questionnaire in the Student Health Portal
- ☐ Section 2, Parts II and III of Section 3, and Section 4 are complete and signed by a healthcare provider
- ☐ Section 1 and Part I of Section 3 are completed by the student
- ☐ Section 4 has all of the required vaccines and an official immunization record is attached.

STUDENT SIGNATURE

I confirm that I have reviewed all sections of the health form and they have been completed by myself and my healthcare provider.

Student Signature

Date

For Internal Use Only	Staff Initials and Date
Received – Banner	
Vaccines – PyraMed	
Temp Clearance – Banner	
Hold – Banner	
Completed – Banner	

DSU Health Center Staff Signature

Date

LastFirstMiddle Initial

Section 2: Physical Examination (Completed within last year)

/ /

(TO BE COMPLETED BY THE HEALTHCARE PROVIDER)

Date of Physical Exam

HeightWeightBMIBlood PressurePulseRR

Allergies (List all Allergies)

Medications (List all Medications)

	NORMAL	ABNORMAL	IF ABNORMAL, PROVIDE EXPLANATION
1. Head, Eyes, Ears, Nose or Throat			
2. Neurological			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Musculoskeletal			
7. Metabolic/Endocrine			
8. Genitourinary			
9. Hernia			
10. Skin			

RECOMMENDATIONS FOR PHYSICAL ACTIVITY:

- Exercise programs and use of fitness equipment:

☐ Unlimited☐ Limited
- Cleared for participation in athletic activity:

☐ Unlimited☐ Limited
- Is this patient now under treatment for any medical or emotional condition?

☐ Yes☐ No

If yes, please explain

Optional: Enclose treatment plan

HEALTHCARE PRACTITIONER (PHYSICIAN, NURSE PRACTITIONER, PA)

LastFirstTitle

AddressCity

StateZIPPhone/ /

SignatureDate

Last

First

Middle Initial

Section 3: Tuberculosis (TB) Risk Assessment

Part I: Tuberculosis (TB) Screening Questionnaire **(TO BE COMPLETED BY THE STUDENT)**

Afghanistan	China, Macao SAR	Honduras	Morocco	Solomon Islands
Algeria	Colombia	India	Mozambique	Somalia
Angola	Comoros	Indonesia	Myanmar	South Africa
Anguilla	Congo	Iraq	Namibia	South Sudan
Argentina	Congo (Democratic Republic of)	Kazakhstan	Nauru	Sri Lanka
Armenia	Cote d'Ivoire	Kenya	Nepal	Sudan
Azerbaijan	Djibouti	Kiribati	Nicaragua	Suriname
Bangladesh	Dominican Republic	Korea (Democratic People's Republic of)	Niger	Tajikistan
Belarus	Ecuador	Korea (Republic of)	Nigeria	Tanzania (United Republic of)
Belize	El Salvador	Kyrgyzstan	Niue	Thailand
Benin	Equatorial Guinea	Lao People's Democratic Republic	Northern Mariana Islands	Timor-Leste
Bhutan	Eritrea	Lesotho	Pakistan	Togo
Bolivia (Plurinational State of)	Eswatini	Liberia	Palau	Tunisia
Bosnia and Herzegovina	Ethiopia	Libya	Panama	Turkmenistan
Botswana	Fiji	Lithuania	Papua New Guinea	Tuvalu
Brazil	Gabon	Madagascar	Paraguay	Uganda
Brunei Darussalam	Gambia	Malawi	Peru	Ukraine
Burkina Faso	Georgia	Malaysia	Philippines	Uruguay
Burundi	Ghana	Maldives	Qatar	Uzbekistan
Cabo Verde	Greenland	Mali	Romania	Vanuatu
Cambodia	Guam	Marshall Islands	Russian Federation	Venezuela (Bolivarian Republic of)
Cameroon	Guatemala	Mauritania	Rwanda	Viet Nam
Central African Republic	Guinea	Mexico	Sao Tome and Principe	Yemen
Chad	Guinea-Bissau	Micronesia (Federated States of)	Senegal	Zambia
China	Guyana	Moldova (Republic of)	Sierra Leone	Zimbabwe
China, Hong Kong SAR	Haiti	Mongolia	Singapore	

Country of Birth: _____ If not born in the United States, enter the date you entered this country: _____ / _____ / _____

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born in one of the countries or territories listed above that have a high incidence of active TB disease? ☐ Yes ☐ No **(If yes, please CIRCLE the country or territory, above)**

Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? ☐ Yes ☐ No
(If yes, CHECK the countries or territories, above.)

Have you been a resident, volunteer and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities and homeless shelters)? ☐ Yes ☐ No

Have you been a volunteer or healthcare worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: Medically underserved, low-income or using drugs or alcohol? ☐ Yes ☐ No

■ **If the answer to all of the above questions is NO**, no further testing is required.

■ **If the answer to any of the above questions is YES**, you are required to receive TB testing prior to the start of your first enrolled term. This must be a TB Blood Test (IGRA) or a two-step Mantoux tuberculin skin test (TST) within 6 months prior to beginning classes. If TST or TB Blood Test is positive, attach chest X-ray results that were completed in the USA. All TB testing must be the same day or 28 days after any live vaccines.

■ **Even if no further action is required, the healthcare provider must complete Part II of this form.**

Section 3: Tuberculosis (TB) Risk Assessment

Part II: Clinical Assessment by Healthcare Provider **(TO BE COMPLETED BY THE HEALTHCARE PROVIDER)**

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are required to obtain either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

- History of a positive TB skin test or IGRA blood test? (If yes, document below)
- ☐ Yes ☐ No
- History of changes on a prior chest X-ray suggesting inactive or past TB disease?
- ☐ Yes ☐ No
- History of BCG vaccination? (If yes, consider IGRA blood test)
- ☐ Yes ☐ No

TB SYMPTOM CHECK*

Does the student have any of the following signs or symptoms of active pulmonary tuberculosis disease? (Please check.)

- ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis) ☐ Chest pain ☐ Loss of appetite
- ☐ Unexplained weight loss ☐ Night sweats ☐ Fever

*Proceed with additional evaluation to exclude active tuberculosis disease including IRGA testing, chest X-ray, and sputum evaluation as indicated and document as needed below.

TUBERCULIN SKIN TEST (TST) **Enclose official medical record of TST** ☐ N/A

Two-Step Test

(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.)**

TST #1

Result: mm of induration

**Interpretation: Positive Negative

TST #2 | 1 to 3 weeks after first TST is read

Result: mm of induration

**Interpretation: Positive Negative

INTERFERON GAMMA RELEASE ASSAY (IGRA) **Enclose copy of lab report** ☐ N/A

Date Obtained: / / (specify method) QFT-GIT T-Spot Other

Result: Negative Positive Indeterminate Borderline (T-Spot only)

CHEST X-RAY: (REQUIRED IF TST OR IGRA IS POSITIVE) **Enclose copy of USA X-ray report**

Date of Chest X-ray: / / Result: Normal Abnormal

Part III. Management of Positive TST or IGRA **(TO BE COMPLETED BY THE HEALTHCARE PROVIDER)** **Enclose official medical records of report of treatment**

All students with a positive TST or IGRA with no signs of active disease on chest X-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, individuals at increased risk of progression from LTBI to TB disease should be prioritized to begin treatment as soon as possible. Delaware State University reserves the right to refer students with positive test results to the Delaware Division of Public Health for evaluation.

Medication Treatment Plan:

Drug: Dose and Frequency: Treatment Start Date: / / End Date: / /

Section 4: Immunizations

(TO BE COMPLETED BY THE HEALTHCARE PROVIDER)

REQUIRED Immunizations

The following immunizations are REQUIRED to attend Delaware State University. Attach student’s official immunization record, which includes the student’s name.

- ☐ **MMR (MEASLES, MUMPS, RUBELLA) — 2 doses or antibody titers are required.**
Delaware State University requires evidence of immunity to measles, mumps and rubella for all students entering the University. Students born before Jan. 1,1957, are exempt from the MMR requirement. Two doses required. Dose 1 given at age 12 months or later. Dose 2 given at age 4–6 years or later and at least one month after first dose.
- ☐ **POLIO (POLIOMYELITIS) — 3 doses with IPV or OPV, or antibody titers.**
- ☐ **TETANUS-DIPHTHERIA-PERTUSSIS — A Tdap is required within the last 10 years.**
- ☐ **MENINGOCOCCAL QUADRIVALENT (A,C,Y,W — 135) —** Not required for students 24 years old and older (waiver** must be submitted).
2 doses required; booster dose required after the age of 16 years
OR
Penbraya (MenABCWY): 2 doses required at least 6 months apart*
OR
Penmenvy (MenABCWY): 2 doses required at least 6 months apart*
- ☐ **SEROGROUP B MENINGOCOCCAL —** Not required for students 24 years old and older (waiver** must be submitted).
Bexsero: 2 doses required at least 6 months apart* OR **Trumenba:** 2 doses required at least 6 months apart* (**Vaccine series must be completed with the same vaccine brand.**)
OR
Penbraya (MenABCWY): 2 doses required at least 6 months apart*
OR
Penmenvy (MenABCWY): 2 doses required at least 6 months apart*

*If the 2nd dose is given before 6 months, a 3rd dose will need to be administered 4 months after the 2nd dose.
**Waiver can be obtained from the Campus Health Center.

RECOMMENDED Immunizations | Attach student’s official immunization record, which includes the student’s name.

- ☐ COVID-19
- ☐ INFLUENZA (Annual Vaccine)
- ☐ HEPATITIS A
- ☐ HEPATITIS B

Surface Antibody Result: ☐ Reactive ☐ Nonreactive _____ Enclose copy of lab report
- ☐ COMBINED HEPATITIS A and B
- ☐ VARICELLA (Chicken Pox) or history of disease

Antibody Date Titer: ☐ Reactive ☐ Nonreactive _____ Enclose copy of lab report
- ☐ HPV

Note: If you are a student entering the health professions or you are an education major, some of these immunizations or proof of immunity (antibody titer) are required for clinical training or student teaching.

HEALTHCARE PRACTITIONER (PHYSICIAN, NURSE PRACTITIONER, PA): The student has obtained all required immunizations to attend Delaware State University.