REGISTRATION

DSU Fall 2015 New Student Orientation Registration Form

REGISTRATION FORM AND PAYMENT MUST BE RECEIVED BY:

<table>
<thead>
<tr>
<th>Session I</th>
<th>Session II</th>
<th>Session III</th>
<th>Session IV</th>
<th>Transfer Session I</th>
<th>Transfer Session II</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 10</td>
<td>June 17</td>
<td>June 24</td>
<td>July 1</td>
<td>June 18</td>
<td>July 2</td>
</tr>
</tbody>
</table>

1. Confirm your attendance. Orientation is required for all new students, both on-campus and commuting. Choose the appropriate nonrefundable orientation fee:
   - Freshman—$150
   - Transfer—$100

2. Indicate which session you will be attending:
   - Session I: June 10-11
   - Session II: June 17-18
   - Session III: June 24-25
   - Session IV: July 1-2
   - Transfer Session I: June 18
   - Transfer Session II: July 2

3. Register any guests who will accompany you. Students may designate up to two guests. There is a $35 fee for each guest. The fee covers meals as well as orientation materials. Guests must make their own off-campus housing arrangements if they intend to stay overnight. Indicate the number of guests:
   - None
   - One Guest (add $35 nonrefundable fee)
   - Two Guests (add $70 nonrefundable fee)

4. Calculate your fees. All fees are nonrefundable. The student fee covers fall 2015 New Student Orientation activities.
   - Student Registration: $150.00
   - Transfer Student Registration: $100.00
   - _______ Guests @ $35 per Guest (limit 2): $______ .00
   - Total: $______ .00

5. Send your completed registration form and payment. Indicate the form of payment below. Payments in the form of a check and credit card should be made online. (Out-of-state checks must be certified.)

   Form of Payment (Please make cashier’s checks and money orders payable to: Delaware State University. If paying by credit card, please read the online QuikPAY instructions.)
   - Cashier’s Check
   - Money Order
   - Credit Card

   ✓ If paying by credit card, please submit online via QuikPAY via the Pay Your Fees link under Resources at the bottom of the front page of the DSU website — desu.edu.

   QuikPAY payment confirmation number

   ✓ Payment in the form of cashier’s check and money order can also be sent to:
     Delaware State University
     Office of the Cashier
     1200 North DuPont Highway, Dover, DE 19901-2277
     Phone: 302.857.6220 | Fax: 302.857.6249

QUESTIONS?
   Contact the Office of Admissions
   1200 North DuPont Highway, Dover, DE 19901-2277
   Toll-free: 800.845.2544 | Phone: 302.857.6351
   Fax: 302.857.6352
   desu.edu

HOW TO MAKE A PAYMENT VIA QUIKPAY

   Step 1: Log on to desu.edu
   Step 2: Select: “Pay Your Fees” link under Resources at the bottom of the front page of the DSU website
   Step 3: In the “Login as Guest Box”
     ✓ Enter: Student ID
     ✓ Click: Login
     ✓ Click: “Yes, connect to the NelNet Website”
     Select: Make a payment
       (Note: In the next step, there will not be an option for New Student Orientation; select Tuition & Other University Fees.)
     ✓ Click: “Pay” for Tuition & Other University Fees
     Select term: Fall 2015
     ✓ Enter payment amount: $150 for freshman or $100 for transfer student
     Payment method:
       (select your method)
     Select: Continue (proceed to enter your payment information)
## Delaware State University Student Health Form

All students are required to file all four pages of this form with Student Health Services

- SECTION 1 is to be completed and signed by YOU. All information must be in English. Please print clearly.
- SECTIONS 2–4 must be completed and signed by a HEALTH CARE PROVIDER ONLY.

All of the information provided is strictly for the use of the Student Health Center and will not be released without student consent. To protect your privacy, return this form to: Delaware State University, Student Health Center, 1200 North DuPont Highway, Bldg. #21, Dover, DE 19901. Faxed copies will not be accepted.

### Section 1: Report of Medical History

<table>
<thead>
<tr>
<th>Family History</th>
<th>Family Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>Age</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
</tr>
</tbody>
</table>

### Personal History

<table>
<thead>
<tr>
<th>HAVE YOU HAD?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scarlet Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>German Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Problems</td>
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<tr>
<td>Surgery</td>
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<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
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<tr>
<td>Tonsillitis</td>
<td></td>
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</tr>
<tr>
<td>Hernia Repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gallbladder Problems</td>
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</tr>
</tbody>
</table>

### Emergency Contact Information

Last: ___________________  First: ___________________  Middle Initial: ___________________

Street Address: ___________________  City: ___________________  State: ___________________

ZIP: ___________________  Telephone No.: ___________________  Email Address: ___________________

DSU Student ID No.: ___________________  Social Security No.: ___________________  Date of Entry: ___________________

Date of Birth: ___________________  Country of Birth: ___________________

Boarder: [ ] Check here if you plan to stay in campus housing

Commuter: [ ] Check here if you plan to live off campus

Semester Entering: [ ] Fall  [ ] Spring

Status: (Select all that apply)  [ ] Full-time  [ ] Part-time  [ ] Graduate  [ ] Undergraduate

**If you will be under age 18 at the time of enrollment, it is very important that the Student 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 the Student Health Services of Delaware State University to render medical care to my dependent

Signed: ___________________  Date: ___________________

Your signature indicates permission for the Student 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.

Reviewed by DSU Health Center Staff  Date: ___________________
Section 2: Physical Examination (Completed within last year)

Date of Physical Exam

Height

Weight

BMI

Blood Pressure

Pulse

RR

Urine Dipstick: □ Normal □ Abnormal Explain: ____________________________________________

Vision: Right 20/__________ Left 20/__________ □ Corrected □ Uncorrected □ Glasses □ Contacts

Allergies (List all Allergies)

Medications (List all Medications)

Recommendations for Physical Activity:

- Exercise programs and use of fitness equipment: □ Unlimited □ Limited
- Recreational (intramural) Sports Flag Football, Basketball, Softball, Soccer, Dodgeball: □ Unlimited □ Limited
- Tryout/walk-on for varsity sports (list sports) ____________________________________________
- Is this patient now under treatment for any medical or emotional condition? □ Yes □ No

If yes, please explain

Optional: Enclose treatment plan

Health Care Practitioner (Physician, Nurse Practitioner, PA):

Last

First

Title

Address

City

State

ZIP

Phone

Signature

Date
Section 3: Tuberculosis (TB) Risk Assessment

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) within 6 months prior to campus arrival, unless a previous positive test has been documented. A chest X-ray is required if TST or IGRA is positive. **All questions must be answered even if TST is performed.**

- Recent close contact with someone with infectious TB disease: ☐ Yes ☐ No
- Foreign-born (outside continental U.S.) from (or travel* to/in) a high-prevalence area, e.g., Africa, Asia, Eastern Europe, or Central or South America: ☐ Yes ☐ No
- Fibrotic changes on a prior chest X-ray suggesting inactive or past TB disease: ☐ Yes ☐ No
- HIV/AIDS: ☐ Yes ☐ No
- Organ transplant recipient: ☐ Yes ☐ No
- Immunosuppressed (equivalent of >15 mg/day of prednisone for >1 month or TNF-antagonist): ☐ Yes ☐ No
- History of illicit drug use: ☐ Yes ☐ No
- Resident, employee, or in a high risk of progressing to TB disease if infected (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities): ☐ Yes ☐ No
- Medical condition associated with increased risk of progressing to TB disease if infected, e.g., diabetes mellitus, silicosis, head, neck or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin’s disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight — i.e., 10% or more below ideal for the given population: ☐ Yes ☐ No
- Does the student have signs of active tuberculosis disease? ☐ Yes ☐ No

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

**If the answer is YES to any of the above questions, a 2-step TST or an IGRA is required.**

- **Tuberculin Skin Test (TST): 2 TST steps required**
  (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.)**
  
  Date Given: ____________  Date Read: ____________  Result:____mm of induration  Interpretation**: ☐ Positive ☐ Negative
  
  Date Given: ____________  Date Read: ____________  Result:____mm of induration  Interpretation**: ☐ Positive ☐ Negative

- **Interferon Gamma Release Assay (IGRA)**
  
  Date Obtained: ____________  Method: ☐ QFT-G ☐ QFT-GIT ☐ Other ** Enclose copy of lab report
  
  Result: ☐ Negative ☐ Positive ☐ Intermediate

- **Chest X-ray:** *(Required if TST or IGRA is positive)*
  
  Date of chest X-ray: ____________  Result: ☐ Normal ☐ Abnormal ** Enclose copy of X-ray report

- **Medication Treatment Plan:**
  
  Drug: _____________________  Dose: _____________________  Frequency: _____________________
  
  Treatment completion date: ____________

Health Care Provider Signature (Physician, Nurse Practitioner, PA):

__________________________  ______________________
Signature  Date
Section 4: Immunizations (Required)

M.M.R. (Measles, Mumps, Rubella)
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.

**MMR Dates:** #1 ____________, #2 ____________

**Measles Dates:** #1 ____________, #2 ____________ or **Antibody Titer:** *Enclose copy of lab report for Titers

**Mumps Dates:** #1 ____________, #2 ____________ or **Antibody Titer:** *Enclose copy of lab report for Titers

**Rubella Dates:** #1 ____________, #2 ____________ or **Antibody Titer:** *Enclose copy of lab report for Titers

**Polio (Poliomyelitis)**
Initial Dates of polio series: #1 ____________, #2 ____________, #3 ____________

**Last booster:** ____________ **If polio series is not completed, enclose copy of lab report for Titers**

**Tetanus-Diphtheria-Pertussis**
Completed primary series of tetanus-diphtheria-pertussis immunizations: ____________

**Received tetanus-diphtheria booster within last 10 years:** ____________

**Booster:** Tdap to replace a single dose of Td.

**Tdap booster:** ____________

**Meningococcal Meningitis Vaccine**

- Dose #1: ____________
- Dose #2: ____________

New CDC Recommendations (3/11)
All adolescents and teens ages 11 through 18 years should be vaccinated with MenactraTM or Mencevax®, as should unvaccinated young adults 19 through 21 years who are attending college. Booster doses will be necessary for those who got their first dose before age 16 years.

**Recommended Immunizations**

- **HEPATITIS A Dates:** #1 ____________, #2 ____________, #3 ____________
- **HEPATITIS B Dates:** #1 ____________, #2 ____________, #3 ____________
- **HEPATITIS B Surface Antibody Result:** Reactive or Nonreactive

**COMBINED HEPATITIS A and B Dates:** #1 ____________, #2 ____________, #3 ____________

**VARICELLA (Chicken Pox) Dates:** #1 ____________, #2 ____________, #3 ____________

**Antibody Date Titer:** Reactive or Nonreactive

**HPV (Gardasil) Dates:** #1 ____________, #2 ____________, #3 ____________

**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.

Health Care Provider Signature (Physician, Nurse Practitioner, PA):

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