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
- Session II: June 14
- Session III: June 17
- Session IV: July 1
- Transfer Session I: June 12
- Transfer Session II: July 3

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 and amenities. 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 all fall 2013 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.)

- Cashier’s Check
- Money Order
- Credit Card

If paying by credit card, please submit online via QuikPay via the Make a Payment button on the front page of the DSU website — desu.edu.

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: 302.857.6202

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 my.desu.edu
Step 2: Select: “QuikPAY” icon
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; it will be listed under Tuition/Traditional Housing.)
- Click: “Pay” for Tuition/Traditional Housing (the last “PAY” button)
- Select: Fall 2013
- Enter: $150 for freshman or $100 for transfer student
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.

Last Name First Name 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 If not born in the USA, indicate the date you entered this country
Boarder: ☐ Check here if you plan to stay in campus housing
Commuter: ☐ Check here if you plan to live off campus

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

Emergency Contact Information
Last Name First Name Telephone/Cell No.

Section 1: Report of Medical History

<table>
<thead>
<tr>
<th>FAMILY HISTORY</th>
<th>FAMILY HEALTH</th>
<th>YES</th>
<th>NO</th>
<th>RELATIONSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship</td>
<td>Age</td>
<td>State of Health</td>
<td>Occupation</td>
<td>Age at Death</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
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<tr>
<td>Sister</td>
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<td>Sister</td>
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<td>Brother</td>
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<tr>
<td>Brother</td>
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</tbody>
</table>

HAVE YOU HAD? YES NO
Scarlet Fever
Measles
German Measles
Mumps
Chicken Pox
Malaria
Dental Problems
Sinusitis
Eye Problems
Surgery
Appendectomy
Tonsillectomy
Hernia Repair
Other
 Gallbladder Problems

HAVE YOU HAD? YES NO
Insomnia
Anxiety Attacks
Depression
Recurrent Headache
Recurrent Colds
Fainting
Tuberculosis
Asthma
Chronic Cough
Rheumatic Fever
Jaundice
Concussions
Fractures
Joint Disease
Joint Injury

HAVE YOU HAD? YES NO
Back Problems
Hernia
Stomach Problems
Intestinal Problem
Constipation
Recurrent Diarrhea
Weight Gain
Weight Loss
Colitis
Cancer
Tobacco Use
Tumor
Diabetes
Low Blood Sugar
Dizziness/Vertigo

HAVE YOU HAD? YES NO
STDs
Chronic Rash
Anemia
Weakness/Paralysis
Frequent Urination
Shortness of Breath
Chest Pain/Pressure
Palpitations
Convulsion/Seizure

FEMALES ONLY
PMS Symptoms
Heavy Flow
Severe Cramps
Irregular Periods
Ovarian Cyst

*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 parent(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)

<table>
<thead>
<tr>
<th>Date of Physical Exam</th>
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<tbody>
<tr>
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</tbody>
</table>

### Medical History

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>RR</th>
</tr>
</thead>
</table>

### 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

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

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Title</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
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</table>

<table>
<thead>
<tr>
<th>State</th>
<th>ZIP</th>
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</table>

<table>
<thead>
<tr>
<th>Phone</th>
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<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
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</tbody>
</table>
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 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 prednisone for > 1 month or TNF-antagonist): 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, TST or 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, Nurse):

_________________________ / ____________ / ____________
Signature Date
Section 4: Immunizations

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.

<table>
<thead>
<tr>
<th>Dates</th>
<th>#1</th>
<th></th>
<th>#2</th>
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</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<td></td>
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<tr>
<td>Rubella</td>
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</tbody>
</table>

*Enclose copy of lab report for Titers

Polio (Poliomyelitis)
Completed primary series of polio immunization:  /  /
Last booster:  /  /

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 for booster immunization with at least 2–5 years since last dose of Td.
(Administer with MCV4 simultaneously if possible):  /  /

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 Menactra™ or Menveo®, 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
- Nonreactive  /  /

Enclose copy of lab report

COMBINED HEPATITIS A and B Dates:  
- #1:  /  /
- #2:  /  /
- #3:  /  /

VARICELLA (Chicken Pox) Dates:  
- #1:  /  /
- #2:  /  /
- or history of disease

Antibody Date Titer:  
- Reactive
- Nonreactive  /  /

Enclose copy of lab report

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, Nurse):

/  /