Student Health Policy

All full-time incoming freshmen and transfer students are required to complete and return the Health Form to the Delaware State University Student Health Center on or before:

- July 1 for fall semester
- Dec. 1 for spring semester

The health form must be filled out clearly and completely with the following information:

1. Report of Medical History
   (To be completed by the student or parent/legal guardian.)
   - ☐ Family history
   - ☐ Personal history
   - ☐ Signed and dated (by student if over 18 years of age)
   - ☐ Parental consent for treatment if the student is under the age of 18
     (parent signature is required)

2. Health Evaluation
   (Sections 2-4 must be completed by a health care provider.)
   - ☐ A completed physical exam is required
   - ☐ Immunization requirements:
     - 2 measles, mumps, and rubella (MMR) vaccines or serological evidence (blood test) of your immunity; a tetanus/diphtheria (Td) booster within the last 10 years
     - Tdap to replace a single dose of Td for booster immunization with at least 2-5 years since last dose of Td to prevent pertussis (whooping cough).
   - ☐ Tuberculosis screening (Mantoux or PPD test) All incoming students are required to have a TB risk assessment within the 6 months prior to campus arrival. Persons with any risk factors must have either the Mantoux Tuberculin Skin Test (TST) or interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. A chest X-ray is required if TST or IGRA is positive.
   - ☐ Meningitis vaccine (Booster dose required if vaccine received before age 16.)

The original copy of the health form is required. Faxed copies will NOT be accepted. For more information, please contact Student Health Services at 302.857.6393.

ANY STUDENT FAILING TO COMPLY WITH THE HEALTH POLICY WILL NOT BE CLEARED TO MOVE INTO UNIVERSITY HOUSING AND WILL BE INELIGIBLE TO RECEIVE SERVICES AT THE STUDENT HEALTH CENTER.

All original forms must be mailed directly to the Office of Student Health Services. Do not mail health forms to other departments. Faxed copies will not be accepted. Students are advised to keep a copy of the health form for their records. Students bringing the health form with them to campus must bring all original forms to the Office of Student Health Services. If you have any questions concerning the health form, contact the Office of Student Health Services.

Student Health Services | Student Health Center, Bldg. #21 | 1200 North DuPont Highway, Dover, DE 19901 | 302.857.6393
# Delaware State University Student Health Form

All students are required to fill out 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, 7200 North DuPont Highway, Bldg. 921, Dover, DE 19901. Faxed copies will not be accepted.

## Personal Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Street Address</td>
<td>City</td>
</tr>
<tr>
<td>ZIP</td>
<td>Telephone No.</td>
</tr>
<tr>
<td>DSU Student ID No.</td>
<td>Social Security No.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Country of Birth</td>
</tr>
<tr>
<td>Boarder:</td>
<td>Check here if you plan to stay in campus housing</td>
</tr>
<tr>
<td>Commuter:</td>
<td>Check here if you plan to live off campus</td>
</tr>
<tr>
<td>Status:</td>
<td>□ Full-time □ Graduate □ Undergraduate</td>
</tr>
</tbody>
</table>

## Emergency Contact Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Telephone/Cell No.</td>
<td></td>
</tr>
</tbody>
</table>

## Family History

<table>
<thead>
<tr>
<th>Relationship</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age at Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td>Tobacco Lung</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease</td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Medical History

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Section 1: Report of Medical History

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Personal History

<table>
<thead>
<tr>
<th>Procedure</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendectomy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia Repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Additional Information

- 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: 

Student Signature: 

Date: 

Reviewed by DSU Health Center Staff: 

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.
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)

| 1. Head, Eyes, Ears, Nose or Throat | NORMAL | ABNORMAL | IF ABNORMAL, PROVIDE EXPLANATION |
| 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
- 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, Nurse):

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 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
- Immunocompromised (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, 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):

_____________________________ 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.

MMR Dates:    #1 / /    #2 / /
Measles Dates:    #1 / /    #2 / / or Antibody Date Titer: / /    
Mumps Dates:    #1 / /    #2 / / or Antibody Date Titer: / /    
Rubella Dates:    #1 / /    #2 / / or Antibody Date Titer: / /    

*Enclose copy of lab report for Titors

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 Menevo®, 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 / /    
COMBINED HEPATITIS A and B Dates:    #1 / /    #2 / /    #3 / /    
VARICELLA (Chicken Pox) Dates:    #1 / /    #3 / /    
Antibody Date Titer:    ☐ Reactive ☐ Nonreactive / /    
HPV (Gardasil) Dates:    #1 / /    #2 / /    #3 / /    

Enclose copy of lab report or history of disease

Enclose copy of lab report

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): / /    
Signature Date