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 ____________ First ____________ Middle Initial ____________

Street Address ____________ City ____________ State ____________

ZIP ____________ Telephone No. ____________ Email Address ____________

DSU Student ID No. ____________ **Semester Entering:** ☐ Fall ☐ Spring ____________ Year

__ / __ / __ 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 ____________ First ____________ Telephone/Cell No. ____________

Section 1: Report of Medical History

FAMILY HISTORY					
Relationship	Age	State of Health	Occupation	Age at Death	Cause of Death
Mother					
Father					
Sister					
Sister					
Brother					
Brother					

FAMILY HEALTH	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Arthritis			
Heart Disease			
Stomach Disorders			
Asthma			
Epilepsy			

PERSONAL HISTORY

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 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.

Student Signature ____________ __ / __ / __ Date

Reviewed by DSU Health Center Staff ____________ __ / __ / __ Date

Last First Middle Initial

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)

	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
- 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

Last First Middle Initial

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, China, Korea, 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

Last First Middle Initial

Section 4: Immunizations

The following immunizations are **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 ___/___/___ ** If polio series is not completed, enclose copy of lab report for Titers

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.

Tdap booster: ___/___/___

Meningococcal Meningitis Vaccine

❐ Dose #1: ___/___/___

❐ Dose #2: ___/___/___

New CDC Recommendations (3/11)

Booster doses will be necessary for those who got their first dose before age 16 years, followed by Booster Dose #2.

Recommended Immunizations

SEROGROUP B Meningococcal Vaccine (Men B): #1 ___/___/___

HEPATITIS A Dates: #1 ___/___/___ #2___/___/___

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):

Signature _______________________ Date ___/___/___