Delaware State University Student Health Form

All full-time incoming U.S. and international students — both residential and commuter — are required to complete a Student Health Form.

Note: New students who plan to live on campus will not be permitted to move into the residence halls without a completed health form on file in the Office of Student Health Services.

TWO-STEP PROCESS

There is a 2-step process to completing your required health forms.

2. Mail in a completed Health Form to:

   Delaware State University
   Campus Health Center
   1200 North DuPont Highway, Dover, DE 19901

HOW TO COMPLETE THE MAIL-IN FORM

□ SECTION 1 (signature required) and SECTION 3 (PART I) are to be completed by YOU. All information must be in English. Please print clearly.
□ SECTIONS 2, 3 (PARTS II and III), 4 must be completed and signed by a HEALTH CARE PROVIDER ONLY.

All of the information provided is strictly for the use of the Campus Health Center and will not be released without student consent.
To protect your privacy, return this form to the mailing address above. Faxed copies will not be accepted.

Section 1: Your Personal Information, Signed Consent and Acknowledgment

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle Initial</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City</th>
<th>State</th>
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<table>
<thead>
<tr>
<th>ZIP</th>
<th>DSU Email Address</th>
<th>Student Telephone Number</th>
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</table>

Delaware State University Student ID Number

Semester Entering: □ Fall □ Spring

Year

Date of Birth

Gender Identity

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:

<table>
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<tr>
<th>Last</th>
<th>First</th>
<th>Telephone/Cell Number</th>
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*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.

STUDENT SIGNATURE

I confirm that all forms have been completed.

__________________________________________________________
Student Signature          Date

Reviewed by Delaware State University Health Center Staff          Date
Section 2: Physical Examination (Completed within last year)

Date of Physical Exam: / / 

<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)

<table>
<thead>
<tr>
<th>Topic</th>
<th>Normal</th>
<th>Abnormal</th>
<th>IF ABNORMAL, PROVIDE EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Eyes, Ears, Nose or Throat</td>
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<tr>
<td>2. Neurological</td>
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<td>3. Respiratory</td>
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<td>4. Cardiovascular</td>
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<td>6. Musculoskeletal</td>
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<td>7. Metabolic/Endocrine</td>
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<td>8. Genitourinary</td>
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<tr>
<td>9. Hernia</td>
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<tr>
<td>10. Skin</td>
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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

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

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

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<tr>
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<th>Haiti</th>
<th>Mozambique</th>
<th>Singapore</th>
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<td>Rwanda</td>
<td>Venezuela (Bolivarian Republic of)</td>
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<td>Micronesia (Federated States of)</td>
<td>Sao Tome and Principe</td>
<td>Viet Nam</td>
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<td>Zimbabwe</td>
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Country of Birth: ____________________________________________  If not born in the United States, enter the date you entered this country: _______ / _______ / _______

To the best of your knowledge have you ever had close contact with anyone who was sick with TB? ☐ 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 traveled or lived for more than one month in any country or territory listed above that have a high prevalence of TB disease? ☐ Yes ☐ No

(If yes, CHECK the countries or territories, above.) The significance of the travel exposure should be discussed with a health care provider and evaluated.

Have you been a volunteer, employee, or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility, or other health care facility? ☐ Yes ☐ No

Do you have a history of illicit drug use or alcohol abuse? ☐ Yes ☐ No

Do you have a medical condition associated with increased risk of progressing TB disease if infected, such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. Prednisone > 15mg/day for > 1 month), or other immunosuppressive disorders, or are you an organ transplant recipient? ☐ 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 have a two-step Mantoux tuberculin skin test (TST) or TB Blood Test (IGRA) 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 health care provider must complete Part II of this form.
Section 3: Tuberculosis (TB) Risk Assessment

Part II: Clinical Assessment by Health Care Provider (TO BE COMPLETED BY THE HEALTH CARE PROVIDER)

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for 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)

History of changes on a prior chest X-ray suggesting inactive or past TB disease?

History of BCG vaccination? (If yes, consider IGRA blood test)

1. TB SYMPTOM CHECK

Does the student have signs or symptoms of active pulmonary tuberculosis disease? 

If No, sign here ________________________________.

If Yes, check below AND also proceed to 2 or 3.

☐ 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 tuberculin skin testing, chest X-ray, and sputum evaluation as indicated.

2. TUBERCULIN SKIN TEST (TST)

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.)**

Date Given: ____________________ Date Read:  ____________________

Result: ______ mm of induration **Interpretation: Positive ______ Negative ______

Second TST  |  1 to 3 weeks after first TST is read

Date Given: ____________________ Date Read:  ____________________

Result: ______ mm of induration **Interpretation: Positive ______ Negative ______

3. INTERFERON GAMMA RELEASE ASSAY (IGRA) Enclose copy of lab report

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

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

4. 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 HEALTH CARE PROVIDER)

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:  / /

Health Care Professional’s Signature            Date
Section 4: Immunizations

(TO BE COMPLETED BY THE HEALTH CARE PROVIDER)

The following immunizations are REQUIRED.

A  MMR (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

B  POLIO (POLIOMYELITIS)

Completed primary series of Polio: Immunization Date: ______/_____/______  Last Booster: ______/_____/______

C  TETANUS-DIPHTHERIA-PERTUSSIS

Completed primary series of tetanus-diphtheria-pertussis immunizations: ______/_____/______  Date of last dose in series: ______/_____/______

Tdap Booster within the last 10 years:  Date ______/_____/______

Date of most recent booster dose: ______/_____/______  Type of booster:  Td___________ or Tdap________________

D  MENINGOCOCCAL QUADRICOSTATE (A,C, Y, W — 135)

Dose #1: ______/_____/______  Dose #2: ______/_____/______  *Booster doses will be necessary for those who got their first dose before age 16 years, followed by Booster Dose #2.

E  SEROGROUP B MENINGOCOCCAL (Vaccine series must be completed with the same vaccine)

Besexero:  Dose #1: ______/_____/______  Dose #2: ______/_____/______  OR

Trumenba:  Dose #1: ______/_____/______  Dose #2: ______/_____/______  Dose #3: ______/_____/______

F  COVID-19

Dose #1: ______/_____/______  Dose #2: ______/_____/______  Type:  □ Pfizer  □ Moderna  □ Janssen/J&J

RECOMMENDED IMMUNIZATIONS

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 ______/_____/______, \#3 ______/_____/______  or history of disease
Antibody Date Titer:  □ Reactive  □ Nonreactive  ______/_____/______  Enclose copy of lab report
HPV Dates:  \#1 ______/_____/______, \#2 ______/_____/______, \#3 ______/_____/______  Indicate preparation if known:  Quadrivalent (HPV4)_________ or Bivalent (HPV2)_________ or 9-valent (HPV9)

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 PRACTITIONER (PHYSICIAN, NURSE PRACTITIONER, PA):

Signature  Date