Delaware State University Student Health 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) and 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 _____ Email Address _____ Telephone Number _____

Delaware State University Student ID Number _____ **Semester Entering:** ❑ Fall ❑ Spring _____ Year

Date of Birth / / Gender Identity _____ 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 Number

Section 1: Report of Medical History

FAMILY HISTORY						FAMILY HEALTH	YES	NO	RELATIONSHIP
Relationship	Age	State of Health	Occupation	Age at Death	Cause of Death	Tuberculosis			
Mother						Diabetes			
Father						Kidney Disease			
Sister						Arthritis			
Sister						Heart Disease			
Brother						Stomach Disorders			
Brother						Asthma			
						Epilepsy			

PERSONAL HISTORY

HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO	HAVE YOU HAD?	YES	NO
Scarlet Fever			Insomnia			Back Problems			STDs			**FEMALES ONLY**		
Measles			Anxiety Attacks			Hernia			Chronic Rash			PMS Symptoms		
German Measles			Depression			Stomach Problems			Anemia			Heavy Flow		
Mumps			Recurrent Headache			Intestinal Problem			Weakness/Paralysis			Severe Cramps		
Chicken Pox			Recurrent Colds			Constipation			Frequent Urination			Irregular Periods		
Malaria			Fainting			Recurrent Diarrhea			Shortness of Breath			Ovarian Cyst		
Dental Problems			Tuberculosis			Weight Gain			Chest Pain/Pressure					
Sinusitis			Asthma			Weight Loss			Palpitations					
Eye Problems			Chronic Cough			Colitis			Convulsion/Seizure					
Surgery			Rheumatic Fever			Cancer			Sickle Cell Trait					
Appendectomy			Jaundice			Tobacco Use			Sickle Cell Anemia					
Tonsillectomy			Concussions			Tumor								
Hernia Repair			Fractures			Diabetes								
Other			Joint Disease			Low Blood Sugar								
Gallbladder Problems			Joint Injury			Dizziness/Vertigo								

***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 Delaware State University 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

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

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 below that have a high incidence of active TB disease? ❑ Yes ❑ No (**If yes, please CIRCLE the country or territory, below**)

Afghanistan	China, Hong Kong SAR	Guyana	Morocco	Singapore
Albania	China, Macao SAR	Haiti	Mozambique	Solomon Islands
Algeria	Colombia	Honduras	Myanmar	Somalia
Angola	Comoros	India	Namibia	South Africa
Anguilla	Congo	Indonesia	Nauru	South Sudan
Argentina	Côte d'Ivoire	Iraq	Nepal	Sri Lanka
Armenia	Democratic People's Republic of Korea	Kazakhstan	Nicaragua	Sudan
Azerbaijan	Democratic Republic of the Congo	Kenya	Niger	Suriname
Bangladesh	Djibouti	Kiribati	Nigeria	Swaziland
Belarus	Dominican Republic	Kuwait	Niue	Tajikistan
Belize	Ecuador	Kyrgyzstan	Northern Mariana Islands	Tanzania (United Republic of)
Benin	El Salvador	Lao People's Democratic Republic	Pakistan	Thailand
Bhutan	Equatorial Guinea	Latvia	Palau	Timor-Leste
Bolivia (Plurinational State of)	Eritrea	Lesotho	Panama	Togo
Bosnia and Herzegovina	eSwatini	Liberia	Papua New Guinea	Tunisia
Botswana	Ethiopia	Libya	Paraguay	Turkmenistan
Brazil	Fiji	Lithuania	Peru	Tuvalu
Brunei Darussalam	French-Polynesia	Madagascar	Philippines	Uganda
Bulgaria	Gabon	Malawi	Portugal	Ukraine
Burkina Faso	Gambia	Malaysia	Qatar	Uruguay
Burundi	Georgia	Maldives	Republic of Korea	Uzbekistan
Cabo Verde	Ghana	Mali	Republic of Moldova	Vanuatu
Cambodia	Greenland	Marshall Islands	Romania	Venezuela (Bolivarian Republic of)
Cameroon	Guam	Mauritania	Russian Federation	Viet Nam
Central African Republic	Guatemala	Mexico	Rwanda	Yemen
Chad	Guinea	Micronesia (Federated States of)	Sao Tome and Principe Senegal	Zambia
China	Guinea-Bissau	Mongolia	Sierra Leone	Zimbabwe

Have you traveled or lived for more than one month in any country or territory listed above with 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 or further action is required.
- **If the answer to any of the above questions is YES**, you are required to have a 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 and sign and date the back of this page.***

Last First Middle Initial

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) ❑ Yes ❑ No

History of changes on a prior chest X-ray suggesting inactive or past TB disease? ❑ Yes ❑ No

History of BCG vaccination? (If yes, consider IGRA blood test) ❑ Yes ❑ No

1. TB SYMPTOM CHECK

Does the student have signs or symptoms of active pulmonary tuberculosis disease? ❑ Yes ❑ No

If No, proceed to 2 or 3.

If Yes, check below:

❑ 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)

(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 _____

Please record dates as:
____/____/____
M D Y

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

Last First Middle Initial

Section 4: Immunizations

The following immunizations are REQUIRED.

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

POLIO (POLIOMYELITIS)

Completed primary series of Polio: Immunization Date: ____/____/____ Last Booster: ____/____/____

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_____

Please record dates as:
____/____/____
M D Y

MENINGOCOCCAL MENINGITIS VACCINE
MCV4: Menactra or Menveo or Menomune

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.

Serogroup B Meningococcal Vaccine (Men B):

Besexero: Dose #1: ____/____/____ Dose #2: ____/____/____
OR
Trumenba: Dose #1: ____/____/____ Dose #2: ____/____/____ Dose #3: ____/____/____
*A Men B waiver can be signed. The waiver is available on the Student Health Center website.

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 ____/____/____ 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