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.

1. Complete online forms electronically by visiting **desu.studenthealthportal.com**.
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

Last _____ First _____ Middle Initial _____

Street Address _____ City _____ State _____

ZIP _____ DSU Email Address _____ Student Telephone Number _____

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: _____
Last First Telephone/Cell Number

***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

I confirm that all forms have been completed.

_____ ___/___/___
Student Signature Date

_____ ___/___/___
Reviewed by Delaware State University Health Center Staff Date

Delaware State University

Last First Middle Initial

Section 2: Physical Examination (Completed within last year)

_____/_____/_____ **(TO BE COMPLETED BY THE HEALTH CARE PROVIDER)**

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)

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

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 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 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.***

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, 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 _____

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

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

Last First Middle Initial

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 QUADRIVALENT (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.

Please record dates as:

____/____/____

M D Y

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 ____/____/____ 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