POST UNIVERSITY
Student Health Services
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PERSONAL AND CONFIDENTIAL

# STUDENT HEALTH FORM

## PART I: TO BE COMPLETED BY STUDENT

**Entering semester:** Fall____ Spring____ Year_____ **Status**: Resident____ Commuter____ **Gender:** Male____ Female____

Last name_____ First_____ Middle_____

Home phone number (___)_____ Cell phone number (___)_____

Address_____ City_____ State_____ Zip_____

Date of Birth_____ / ___ / _____ Country of birth: _____

**In case of an emergency notify:**

1. Full name:_____ Relationship_____

Cell phone: _____ Home phone: _____ Business phone: _____

2. Full name:_____ Relationship_____

Cell phone: _____ Home phone: _____ Business phone: _____

## STUDENT AUTHORIZATION FOR TREATMENT

I hereby authorize the Post University Health Services to provide medical treatment and services they deem appropriate (to include outside providers for medical treatment, physical exams, and immunizations). This authorization will remain in effect as long as I am a student at Post University.

Student's signature: _____ Date: _____

**PARENT / GUARDIAN'S SIGNATURE (FOR STUDENTS UNDER 18 YEARS OLD)**: _____Date: _____

## HEALTH INSURANCE IS MANDATORY FOR ALL FULL-TIME STUDENTS

All full-time students will be billed automatically for the University insurance plan unless a student provides the necessary information through the on-line waiver found at ***http://www.post.edu/maincampus/registrarForms.shtml*** by the first day of classes. Please contact the University's insurance provider with any questions pertaining to the insurance coverage or the waiver at ***(800) 321-4449***. To ease the Health Services office in providing you with treatment or in the event of a medical emergency, please attach a copy of the front and back of the insurance card here:

| FRONT | BACK |
| --- | --- |

## PART II: TO BE COMPLETED BY THE STUDENT

## MEDICAL HISTORY OF THE STUDENT

If you have had any of the following disorders and / or diseases, please indicate at what age on the line provided:

**HEAD / NERVOUS SYSTEM**
___Headaches, recurrent
___Migraine
___Concussion
___Severe head injury
___Seizures / Convulsions
___Dizzy spells / fainting
___Insomnia
___Recurrent anxiety
___Excessive nervousness
___Recurrent depression
___Neuromuscular disorder

**DENTAL**
___Poor teeth / toothaches
___Gum disease

**INFECTIOUS DISEASE**
___Mononucleosis
___Chicken pox
___Rheumatic fever
___TB or positive skin test
___Malaria
___Measles (Rubella)
___Meningitis
___Sexually transmitted disease
___German Measles (Rubella)
___Mumps

**NECK**
___ Swollen glands, frequent
___Thyroid problem / disease

**HEART / LUNGS**
___High cholesterol
___High blood pressure
___Heart murmur
___Palpitations
___Shortness of breath
___Chest pain
___Asthma/wheezing
___Chronic cough
___Pneumonia
___Pleurisy
___Bronchitis
___Do you smoke?

**ALLERGY**
___Hay fever
___Food allergy
___Medicine allergy
___Hives

**PAST HISTORY**
___Operations
___Serious injury / accident
___Emotional problem
___Serious illness

**BLOOD**
___Anemia
___Easy bruising
___Sickle cell anemia/trait

**URINARY**
___Frequent urination
___Painful urination
___Blood in the urine
___Recurrent urinary infection
___Kidney infection
___Kidney stone

**DIGESTIVE**
___Ulcers
___Chronic abdominal pain
___Diarrhea, chronic/recurrent
___Colitis / Ileitis
___Irritable bowel syndrome
___Gallstones
___Hepatitis / jaundice
___Appendectomy
___Hemorrhoid

**OTHER**
___Diabetes
___Malignant disease/cancer
___Anorexia nervosa
___Bulimia

**EYES / EAR / NOSE / THROAT**
___Wear glasses / contacts
___Blindness
___Color blindness
___Eye injury / disease
___Deafness / hearing aid
___Perforated ear drum
___Repeated ear infections
___Repeated nose bleeds
___Frequent sore throats
___Tonsil/adenoid removed
___Sinus infections

**BONES / JOINTS**
___Fractures / dislocations
___Painful joints
___Knee problems
___Paralysis / polio
___Back problems

**SKIN**
___Acne
___Other skin disease

___Weight problem
___Recent weight change

**OTHER HEALTH PROBLEMS:**_____

**MEDICATIONS:**_____

Please note any illnesses or conditions for which you now are under treatment:_____

Please give a brief explanation and approximate date for each illness / condition (you indicated above) that you have had:

I certify to the best of my knowledge that the information on this form is complete and correct.

Students signature:_____ Date: _____

Parent / guardian's signature if under 18 years old: _____ Date: _____

**PART III: TO BE COMPLETED BY A HEALTH CARE PROVIDER**

**EXAMINATION**

Weight_____ Height_____ Blood pressure_____

Vision without glasses_____ Right 20/_____ Left 20/_____ Hearing: Right_____

Vision with glasses_____ Right 20/_____ Left 20/_____ Hearing: Left_____

| SYSTEM | NORMAL | DESCRIBE IF ABNORMAL | REQUIRED |
|---|---|---|---|
| Skin | | | Date: |
| Ears | | | Urinalysis: |
| Eyes | | | Sp. Gr. |
| Nose, throat | | | Sugar |
| Teeth, gingiva | | | Protein |
| Neck, thyroid | | | Micro |
| Chest, breasts | | | Date |
| Lungs | | | Hgb/hct |
| Heart (describe murmur, click, etc.) | | | |
| Abdomen, liver, spleen, kidneys | | | |
| Hernia | | | |
| Genitalia | | | |
| Pelvic (if indicated) | | | |
| Rectal, Pilonidal | | | |
| Extremities, back, spine | | | |
| Lymphatic | | | |
| Neurological | | | |
| Psychological | | | |

1. List all **ALLERGIES** (including medications, insect, etc.) _____

Type of reaction (ie: rash, urticarial, anaphylaxis) _____

2. List all **MEDICATIONS** currently being taken:_____

3. Student's physical restrictions:Unrestricted____ Partial restriction_____ Full restriction_____

Comment: _____

4. Status of student's health: Excellent_____ Good _____ Poor_____

Comment: _____

5. This student is physically qualified to participate in intercollegiate sports: Yes _____ No ____

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Health Care Provider Print Name:_____ Telephone:_____

Address (Street, city, zip): _____

Signature of Health Care Provider: _____ Date of Examination: _____

**Immunizations**

(To be completed by a Health Care Provider)

1. **MMR** (Measles, Mumps, Rubella) – 2 Vaccine dates required by CT law required for all students born after 1/1/1957.
   #1_____(given on or after 1st Bday)
   #2_____(at least 28 days after the first)
   **(Laboratory report must be attached for all titers showing immunity)**
   Measles antibody titer results _____Date_____
   Rubella antibody titer results_____Date_____
   Mumps antibody titer results_____Date_____

2. **Varicella** (chicken pox) – 2 Vaccine dates required by CT law required for all students born after 1/1/1980.
   #1_____(given on or after 1st Bday)
   #2_____(given at least 28 days after the first)
   **OR** Health care providers documentation of disease: Date:_____
   **(Laboratory report must be attached for all titers showing immunity)**
   Varicella antibody titer results_____Date_____

3. **Meningococcal conjugate vaccine** – Given within the past 5 years as required for **Resident Students** by CT law.
   Meningitis_____

4. **Tuberculosis testing** – Required within the past year.

   **(Health care provider to fill out the Tuberculosis pages attached)**

5. **Hepatitis B** (Series of 3 vaccinations)
   #1_____ #2_____ #3_____
   **(Laboratory report must be attached for all titers showing immunity)**
   Hepatitis B antibody titer results_____Date_____

6. Diptheria/Pertussis/Tetanus (from within the past 10 years) _____

7. **Polio** (date series completed) _____

8. **Other vaccines**:_____

Health care provider_____ Signature & Date_____

# Post University Tuberculosis (TB) Assessment

Post Student Health Services http://post.edu/student-services/health-services

| Student Last Name | Student First Name | Student Middle Name |
|---|---|---|
| | | |

| Date of Birth: | Legal Gender: | Preferred Gender Identity: | Student ID |
|---|---|---|---|
| | | | |

**YEAR BEGINNING AT POST**_____ ☐ Fall ☐ Spring

## TUBERCULOSIS (TB) RISK QUESTIONNAIRE (Questions a. through d. to be answered by the student)

| | |
|---|---|
| a) Have you ever had a positive tuberculosis skin or blood test in the past? If **YES**, Go to **Chest X-ray / Medication** sections below | ☐ Yes ☐ No |
| b) To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? | ☐ Yes ☐ No |
| ***c)*** Were you born in one of the countries listed below? ***If yes, please circle which one(s) below*** | |
| ***d)*** Have you traveled to or lived for more than one month in one or more of the countries listed? ***If yes, please circle which one(s)*** | ☐ Yes ☐ No |

**IF you answered NO to all questions no further action is required.**

IF you answered YES to any question in b through d you must have a TB blood or skin test and provide the results below. A chest x-ray is not accepted for b through d YES answers.

No exemption for prior BCG. If you have received BCG in the past, a TB blood test is recommended however a TB skin test is accepted.

## TUBERCULOSIS (TB) TESTING (Results below to be documented by healthcare provider.)

**Testing and Chest X-ray (if required) must be done within 6 months prior to the start of school.**

**TB BLOOD TEST (IGRA)**

☐ Quantiferon ☐ T-Spot

**Date:**_____

**Result:**

☐ NEG ☐ POS

**OR TB SKIN TEST (PPD)**

**Date Planted:** _____

**Date Read:** _____

**Interpretation:**

mm of induration: _____

☐ NEG ☐ POS

**CHEST X-RAY**

- Only accepted/required if past or current positive TB skin or blood test.
- Not required if completed treatment for TB

**Chest X-ray Date:**_____

☐ Normal ☐ Abnormal

**MEDICATION TREATMENT**

☐ Latent TB Infection

☐ Active TB Infection

**Date(s):**_____

## Signature of Health Care Practitioner (MD / DO / APRN / PA)

Signature_____ Date_____ Phone_____

Name (print) _____ Address _____

## List of High Risk Tuberculosis Countries

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