POST UNIVERSITY
Student Health Services
800 Country Club Road, P.O. Box 2540
Waterbury, Ct 06723-2540
(203) 596-4503
Fax (203) 841-1179

PERSONAL AND CONFIDENTIAL

STUDENT HEALTH FORM

Post University must have a completed health form on file by August 1st for fall semester and December 1st for spring semester from all residents, commuters, and transfer students. Parts I and II are to be completed by the student prior to being examined by a health care provider. Parts III and IV are to be completed by a health care provider.
Send completed form to: **Health Services, Post University, 800 Country Club Road, Waterbury, CT 06723-2540**

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

Print Student Name_____

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 (Rubeola)
___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 explaination 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: _____

Print Student Name_____

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 ____

Health Care Provider Print Name:_____ Telephone:_____

Address (Street, city, zip): _____

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

Print Student Name_____

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_____
Address_____Phone(___)_____

If providing documentation on other forms please verify the above information is included

Post University Tuberculosis (TB) Assessment

Student Last Name		Student First Name	Student Middle Name
Date of Birth: MM/DD/YYYY	Legal Gender:	Preferred Gender Identity:	Net ID

Year beginning at Post_____ ☐ Fall ☐ Spring ☐ Campus Resident ☐ Commuter ☐ ADP w/on site class

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)*	☐ Yes ☐ No
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 12 months prior to the start of school.

TB BLOOD TEST (IGRA)
Recommended if prior BCG
☐ Quantiferon ☐ T-Spot
Date:_____
Result:
☐ NEG ☐ POS
☐ Indeterminate

OR

TB SKIN TEST (PPD)
Date Planted: _____
Date Read: _____
Interpretation:
☐ NEG ☐ POS
mm of induration: _____

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):_____
List Medication(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
Bahrain
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
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Macedonia
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe

FORWARD THIS FORM AND ANY ATTACHMENTS TO:

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