Student's Last Name_____First_____Date of Birth__/__/__

Please complete this form and return it to Student Health Services. This form must be completed and the immunization requirements met before you will be allowed to attend classes. All information contained in this form will be held in confidence and will not be released to anyone on or off campus without your knowledge and consent.

PERSONAL IDENTIFICATION

Name _____ _____
Last Name First Name Middle Name Preferred Name

Address _____
Street City State Zip

Sex assigned at birth ____ Current gender identity: M/F/T Other _____

Date of Entry ____/_____ Date of Birth ____/____/_____ School ID# _____
M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____

Program of Study: _____

Student Cell Phone: _____ Student Email: _____

Father/Guardian Name: _____ Mother/Guardian Name: _____

Citizenship: □ U.S. □ Other _____

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name _____
Last Name First Name Relationship

Address _____
Street City State Zip

Phone: _____
HOME Telephone Number CELL Telephone Number BUSINESS Telephone Number

HEALTH INSURANCE INFORMATION: Please attach a copy of the front and back of your current Health Insurance Card.

The online insurance waiver *must be completed* unless you desire to purchase the University-sponsored insurance plan.

For more information, check the school's STUDENT ACCOUNTS webpage.

CONSENT FOR TREATMENT/INFORMATION RELEASE

The undersigned herewith:

A. Grants permission to **Jefferson (Philadelphia University + Thomas Jefferson University)** Student Health Services to provide medical care including administration of treatments and medications as necessary. This includes emergency room visits, lab work, x-rays, etc., which may need to be done at local facilities including local emergency departments, hospitals and medical practices, local imaging and lab locations.

B. Authorizes Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services, Disabilities Services and/or Athletic Trainers/Sports Medicine Services to exchange and release information to each other that may affect my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/screening and Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services health evaluation, immunization record, consent for treatment and questionnaire.

C. This form will remain valid until you graduate from Jefferson (Philadelphia University + Thomas Jefferson University) or cease to be enrolled at the University, whichever is earlier.

D. Certifies that the answers to the questions on this Health Record are correct and true.

*Parent/Guardian must co-sign if student is under age 18.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Co Sign Signature if student is a minor Date

DUE DATES:
Fall Semester July 15
Spring Semester January 1

ATTACHMENTS OF IMMUNIZATION RECORDS WILL NOT BE ACCEPTED
Please remind your provider to complete and sign pages 4 & 5

Student's Last Name_____First_____Date of Birth__/__/__

PAST HISTORY SECTION TO BE COMPLETED BY STUDENT/GUARDIAN: Please indicate problems you have now or may have had in the past. Please comment about any positive answers on a separate sheet of paper. **This information is used solely as an aid to provide necessary health care while you are a student. It is considered confidential information and cannot be released to anyone without your permission.**

Abdominal pain/Food intolerance	yes	no
AIDS, ARC, or positive HIV	yes	no
Alcohol Problem	yes	no
Allergies (seasonal)	yes	no
Anemia/Easy Bruising or Bleeding	yes	no
Anorexia	yes	no
Anxiety (frequent)/Nervousness	yes	no
Asthma/Wheezing	yes	no
Back Problems	yes	no
Bee Sting Reaction, EPi pen	yes	no
Bladder Infection (Cystitis)	yes	no
Bleeding Trait (Sickle Cell)	yes	no
Bronchitis	yes	no
Cancer (location_____)	yes	no
Chicken Pox	yes	no
Contacts/Glasses/Visual Problems	yes	no
Dental Problems	yes	no
Depression	yes	no
Diabetes	yes	no
Dizziness/Vertigo	yes	no
Drug dependency	yes	no
Dyslexia	yes	no
Ear Problems	yes	no
Eating Disorder	yes	no
Eczema	yes	no
Emotional or mental health issues	yes	no
Epilepsy	yes	no
Eye Problems	yes	no
Fainting/Dizziness	yes	no
Fibrocystic Breast Disease	yes	no
Gall Bladder Disease	yes	no
Heat Stroke or Exhaustion	yes	no
Headaches (frequent)	yes	no
Stress / Migraine	yes	no
Hearing Loss	yes	no
Heart Problems: Palpitations		
Rheumatic Heart	yes	no
Heart Murmur	yes	no
Chest pain with exercise	yes	no
(if any of above heart issues, must attach cardiologist report)		
Hepatitis	yes	no
Hernia	yes	no
High Blood Pressure	yes	no
Hypoglycemia	yes	no
Insomnia	yes	no
Irritable Bowel Disorder	yes	no
Kidney problems	yes	no
Lyme Disease	yes	no
Marfan Syndrome	yes	no
Menstrual problems	yes	no
Mononucleosis – (give date_____)	yes	no
Nosebleeds	yes	no
Obesity (>20 lbs. overweight)	yes	no
Organ (loss of paired organ)	yes	no
Ovarian cyst	yes	no
Peptic Ulcer (gastric or duodenal)	yes	no
Phlebitis	yes	no
Pneumonia	yes	no
Rheumatoid Arthritis	yes	no

Seizures or Convulsions	yes	no
Last seizure and type_____		
Sinus Problems	yes	no
Sickle Cell trait or disease	yes	no
Stomach Problems	yes	no
Suicide Attempt	yes	no
Date:_____		
Thyroid Problem	yes	no
Do you smoke?	yes	no
How long have you smoked?_____		
How often_____		
Do you use smokeless tobacco?	yes	no
How long? _____		
Do you drink alcohol?	yes	no
Approximate number of drinks per occasion:_____		
Number of drinking occasions per week:_____		
Drug use (past or present)	yes	no
Drug of choice:_____		
Have you ever been hospitalized?	yes	no
Please list reason and dates		
_____		
_____		
Other problems not listed: _____		
_____		
Have you ever had: any broken bones?	yes	no
specify: _____		
Dislocations?	yes	no
specify:_____		
Pain or swelling of muscle or joint?	yes	no
Injury to tendons, ligaments or cartilage	yes	no
AC separation or shoulder injury	yes	no
Blow to the head that knocked you out?	yes	no
Concussion?_____How many?_____		
Injury to the neck or back?	yes	no
Spinal Fusion?	yes	no

***If you require any kind of special accommodations please contact this office asap.**

Family History:

Have any of your relatives had:

Cancer	yes	no
Diabetes	yes	no
Epilepsy	yes	no
Have Sickle Cell Trait	yes	no
Heart Disease	yes	no
Mental Health Disorders	yes	no
High Blood Pressure	yes	no
Kidney Disease	yes	no
Tuberculosis	yes	no

Student's Last Name_____First_____Date of Birth__/__/__

TUBERCULOSIS (TB) SCREENING to be completed by student/guardian and reviewed by Health Care Provider

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ 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, below)

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
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
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
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
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

Are you enrolled in a HEALTH CARE PROFESSIONAL program at **Jefferson** (Philadelphia University + Thomas Jefferson University)? ❑ Yes ❑ No

If the answer is YES to any of the above questions, Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).
If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Student's Last Name_____First_____Date of Birth__/__/__

PHYSICAL ASSESSMENT *To be completed by a health care provider.

Drug & other allergies: (Circle) None or List Allergies_____

Latex allergy: Yes_____No_____(If yes please list type) _____

Pulse_____Respirations_____BP_____Height_____Weight_____BMI ___

EXAM	Normal	Abnormal or additional elements
General	□ NAD □ WNWD	
HEENT	□ Clear □ pupils	
	□ no d/c □no bulging pearly, □ nl light reflex □ MMM □ no exudates or lesions	
Neck	□ Supple □ no bruit □ no lymphadenopathy	
Chest	□ CTA □ symmetric	
Cardiovasc	□ RRR □ no murmur □ nl PMI	
Breast	□ no masses □ deferred □ no discharge □ no lymphadenopathy	
Abdomen	□ Soft, NTND □ no masses □ NABS □ no CVA tend	
GU/GYN	□ no d/c □ no lesions □ nontender □pap (if over 21) □deferred	
Back	□ nontender □ scoliosis □ no deformity □ neg. straight leg lift	
Musc-skel/ext.	□ FROM □ no edema □ N/V intact	
Skin	□ No rash □ no suspicious nevi	
Neuro	□ AAOX3 □ nl reflexes □ CN 2-12 intact □ Sensory nl □ motor func. nl	

Does the Student have signs or symptoms of active tuberculosis disease? NO___YES____.

If YES proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, IGRA testing, chest x-ray, and sputum evaluation as indicated. All results and treatment plans must be included with this record before the student will be permitted on campus.

Prior surgeries: Yes_____No_____Please list: _____

Is this student under treatment for any medical or emotional condition? If yes, explain._____

_____

Limitations, special conditions or dietary needs:_____

Current Medications: (include dosage)_____

Team sports, Club sport, Fitness center, Fitness classes: _____

_____ Full Participation

_____ Limited Participation(describe limitations, restrictions, time frame and if follow -up evaluation needed.)

_____ Participation Contraindicated (list reasons). _____

PROVIDER STATEMENT: This student has been evaluated and found to be in good health and able to participate unless stipulated above.

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ( )
Address	

Student's Last Name_____First_____Date of Birth__/__/__

STUDENT IMMUNIZATION AND TUBERCULOSIS SCREENING DOCUMENTATION

MUST be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in English)

MMR (Measles, Mumps, Rubella) Two doses required at least 28 days apart for students born after 1956 and all health care professional students			
MMR Vaccination	Date Dose 1: / / Date Dose 2: / /	OR Titers	
Measles (Rubeola)	Measles/Rubeola (IgG), antibodies, titer Date: / /	Results: □ POS □ NEG □ EQUIV □ **Lab Report Attached**	
Mumps	Mumps (IgG), antibodies, titer Date: / /	Results: □ POS □ NEG □ EQUIV □ **Lab Report Attached**	
Rubella	Rubella (IgG), antibodies, titer Date: / /	Results: □ POS □ NEG □ EQUIV □ **Lab Report Attached**	
Varicella (Chicken Pox)) Two doses required at least 28 days apart			
	Dose #1 Date: / / Dose #2 Date: / /	**OR**	Varicella (IgG), antibodies, titer Results: □ Date: / / POS □ NEG □ EQUIV □ **Lab Report Attached**
Tetanus/Diphtheria/Pertussis (TDAP) – Required within last 10 years-- Recommended within 5 years of your start date.			
	Vaccine Date: / /		
Hepatitis B Immunity - Copy of titer results required ONLY for health care professional students (PA, OT, RN, Midwifery)			
Primary Hepatitis B Series	Dose #1 Date: / / Dose #2 Date: / / Dose #2 Date: / /	**Secondary Hepatitis B Series** (If no response to primary series)	Dose #4 Date: / / Dose #5 Date: / / Dose #6 Date: / /
QUANTITATIVE Hep B Surface Antibody Date: / / Results: mIU/ml □ **Lab Report Attached**		**QUANTITATIVE** Hep B Surface Antibody Date: / / Results: mIU/ml □ **Lab Report Attached**	
Tuberculosis Screening REVIEWED– Student answered NO to all screening questions and is low risk □ YES □ NO			
PPD (2 step required for Health care professional students)	Date: / / Date: / /	Results: _____in mm Results: _____in mm	□ Positive □ Negative □ Positive □ Negative
IGRA Blood Test (Interferon Gamma Release Assay	Date: / /	Results:	□ Lab Report Attached
Positive History Only: Chest x-ray within 6 months required for all positive results			
Chest X-ray	Date: / /	Results: _	□ **Chest X-ray Report Attached**
Meningitis Vaccination - Mandatory for students planning to reside in **Jefferson (Philadelphia University + Thomas Jefferson University)** housing			
Living in PhilaU Housing □ Yes □ No	Date of vaccine (If answered yes) dose 1___/___/___ dose 2 ___/___/_		Date of declination __/__/__
Hepatitis A (RECOMMENDED)	Dose #1: / / Dose #2: / /	**Combined Hepatitis A & B (RECOMMENDED)**	Dose #1: / / Dose #2: / / Dose #3: / /
HUMAN PAPILLOMAVIRUS VACCINE (HPV4 or HPV9) RECOMMENDED	Dose #1: / / Dose #2: / / Dose #3: / /	**MENINGITIS B VACCINE** (AGES 16-18) (RECOMMENDED)	Dose #1: / / Dose #2: / / Dose #3: / /

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ( )
Address	

MUST BE COMPLETED AND SIGNED. ATTACHMENTS OF IMMUNIZATION RECORDS WILL NOT BE ACCEPTED

Student's Last Name_____First_____Date of Birth__/__/