

Delaware State University Student Health Form

All students are required to file all four pages of this form with Student Health Services

All four pages of this form are to be completed and signed by you and your health care provider. All information must be in English.

Please print clearly. Sections 2–4 must be completed 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 N. DuPont Highway, Bldg #21, Dover, Delaware, 19901. Faxed Copies will not be accepted.

Last	First	M.I.
Street Address	City	State
ZIP	Telephone No.	Email Address / /
DSU Student ID No. / /	Social Security No.	Date of Entry / /
Date of Birth	Country of Birth	If not born in the USA, indicate the date you entered this country
Boarder: <input type="checkbox"/> Check here if you plan to stay in campus housing	Status: <input type="checkbox"/> Full-time	<input type="checkbox"/> Graduate <input type="checkbox"/> Undergraduate
Commuter: <input type="checkbox"/> Check here if you plan to live off campus		

Emergency Contact Information

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

*If you will be under age 18 at the time of enrollment it is very important that the Student Health Service 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 healthcare institution in the area.

Student Signature	Date / /
Reviewed by DSU Health Center Staff	Date / /

Last First M.I.

Section 2: Physical Examination

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) _____

Comments

- 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, P.A., Nurse):

Last First M.I.

Signature

Address Phone

City State ZIP

Last

First

M.I.

Section 3: Tuberculosis (TB) Risk Assessment

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) within 6 months prior to campus arrival, unless a previous positive test has been documented. A chest X-ray is required if TST or IGRA is positive.

- Recent close contact with someone with infectious TB disease: Yes No
- Foreign-born from (or travel* to/in) a high-prevalence area, e.g., Africa, Asia, Eastern Europe, or Central or South America: Yes No
- Fibrotic changes on a prior chest X-ray suggesting inactive or past TB disease: Yes No
- HIV / AIDS: Yes No
- Organ transplant recipient: Yes No
- Immunosuppressed (equivalent of >15 mg/day of prednisone for > 1 month or TNF-antagonist): Yes No
- History of illicit drug use: Yes No
- Resident, employee, or in a high risk of progressing to TB disease if infected (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities): Yes No
- Medical condition associated with increased risk of progressing to TB disease if infected, e.g., diabetes mellitus, silicosis, head, neck or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin’s disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight—i.e., 10% or more below ideal for the given population: Yes No
- Does the student have signs of active tuberculosis disease? Yes No
 If the answer is YES to any of the above questions, TST or IGRA is required.
 If the answer to all of the above questions is NO, no further action is required.
- Tuberculin Skin Test (TST): 2 TST steps required
 (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
- Interferon Gamma Release Assay (IGRA)
 Date Obtained: ___ / ___ / ___ Method: QFT-G QFT-GIT Other
 Result: Negative Positive Intermediate
- Chest X-ray: (Required if TST or IGRA is positive)
 Date of chest X-ray: ___ / ___ / ___ Result: Normal Abnormal

**Interpretation Guidelines:

<p>> 5 mm is positive:</p> <ul style="list-style-type: none"> ■ Recent close contact of an individual with infectious TB ■ Persons with fibrotic changes on a prior chest X-ray consistent with past TB disease ■ Organ transplant recipients ■ Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF- antagonist ■ Persons with HIV/AIDS <p>> 15 mm is positive:</p> <ul style="list-style-type: none"> ■ Persons with known risk factors for TB disease 	<p>> 10 mm is positive:</p> <ul style="list-style-type: none"> ■ Persons born in a high prevalence country or who resided in one for a significant* amount of time ■ History of illicit drug use ■ Mycobacteriology laboratory personnel ■ History of resident, worker or volunteer in high-risk congregate settings ■ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemia and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
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*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Health Care Provider (Physician, Nurse Practitioner, P.A., Nurse):

Signature

Date

Last

First

M.I.

Section 4: Immunization

M.M.R. (Measles, Mumps, Rubella)

Delaware State University requires evidence of immunity to measles, mumps and rubella for all students entering the University. Students born before January 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 Date Titer: ___/___/___ *Enclose copy of lab report

Mumps Dates: #1 ___/___/___, #2 ___/___/___ or Antibody Date Titer: ___/___/___ *Enclose copy of lab report

Rubella Dates: #1 ___/___/___, #2 ___/___/___ or Antibody Date Titer: ___/___/___ *Enclose copy of lab report

Polio (Poliomyelitis)

Completed primary series of polio immunization: ___/___/___

Last booster: ___/___/___

Tetanus-Diphtheria-Pertussis

Completed primary series of tetanus-diphtheria-pertussis immunizations: ___/___/___

Received tetanus-diphtheria booster within last 10 years: ___/___/___

Booster: Tdap (preferred) to replace a single dose of Td for booster immunization with at least 2–5 years since last dose of Td, depending on age of patient.
(Administer with MCV4 simultaneously if possible): ___/___/___

Meningococcal Meningitis Vaccine

Menactra™ (Preferred) (MCV4): ___/___/___

Menomune® (MPSV4): ___/___/___

Recommended Immunizations

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.

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 VACCINE Dates: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

VARICELLA (Chicken Pox): #1 ___/___/___ #2 ___/___/___ or History of Disease: Yes No

Antibody Date Titer: ___/___/___ Result: Reactive Nonreactive ___/___/___ Enclose copy of lab report

HPV (Quadrivalent Human Papillomavirus Vaccine) Dates: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

Return This Completed Form:

Delaware State University—Student Health Services
1200 N. DuPont Highway, Building 21
Dover, DE 19901-2277
Phone: 302.857.6393

