HEALTH RECORD FORM

All students are required to file a current health record with Lipscomb University Health Services at the time of enrollment. This information is confidential. ***All sections must be filled out to be considered complete.*** *Please complete both pages and return, by mail or fax,* ***before*** *registration, to:*

Health Center, Lipscomb University,
One University Park Drive, Nashville, TN 37204-3951
Phone: 615.966.6304 Fax: 615.966.5286

Full Name _____ Social Security Number _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____ E-Mail _____

Date of Birth _____ ❑ Female ❑ Male Citizenship ❑ USA ❑ Other (please specify) _____

Name of Parent / Guardian / Spouse (please circle) _____ Phone _____

Address _____
STREET CITY STATE ZIP

Emergency Contact Name & Number _____ Relationship to Student _____

Date you plan to enter by semester (please state year) Fall _____ Spring _____ Summer _____

Student Classification ❑ Fr. ❑ So. ❑ Jr. ❑ Sr. ❑ Dietetic Intern ❑ Student Pharmacist

Former LU student? ❑ Yes ❑ No Last term attended _____ Transfer? ❑ Yes ❑ No

---

MEDICAL HISTORY

❑ Allergy	❑ Dermatology	❑ Hearing/Sight	❑ Anemia	❑ Obesity
❑ High Blood Pressure	❑ Anorexia/Bulimia	❑ Seizure Disorder	❑ Mental Illness	❑ Diabetes
❑ Cardiac/Heart	❑ Gastrointestinal	❑ Immune Disorders	❑ Orthopedic	❑ Thyroid Problem
❑ Genitourinary	❑ Pulmonary/Lung	❑ Headaches/Migraine	❑ Anxiety/Depression	❑ Cancer
❑ Drug/Alcohol Problem	❑ Other _____			

Please **explain** any item marked above (please attach extra sheet if additional space is needed) _____

Please provide allergies or sensitivities ❑ none _____

List any current medications (including regularly taken over-the-counter medications, dietary supplements and herbs) ❑ none _____

In order to ensure good health these assessments are suggested, but not required.

Cholesterol _____ Hct or Hgb _____ Blood Pressure _____ Height _____ Weight _____

HEALTH INSURANCE CARRIED ON LIPSCOMB STUDENT

Policy Number _____ Group Number _____

Name of Insured _____ Name of Insurance Company _____

Insurance Company's Address _____

If a student is under 18 years of age at the time of enrollment, please submit a Consent to Treat Minor Form as well so that (s)he may be seen in the Health Center if needed for illness or injury.

(please see other side)

LIPSCOMB UNIVERSITY

IMMUNIZATION RECORD

To be able to register for classes, each section that is applicable to the student must be filled out. A health care provider must sign the bottom of the form ***OR*** *a copy of an immunization record must be attached to validate the dates of each vaccine listed.*

Full Name _____ **Date of Birth** _____

A. MEASLES, MUMPS AND RUBELLA

The State of Tennessee requires all students, born after 1956, entering college to provide proof of two (2) doses of Measles, Mumps, and Rubella (MMR) vaccine on or after the first birthday and at least 28 days apart. Proof of immunity by IgG titer to all three diseases is also accepted.

REQUIRED for ALL students born after 1956. MMR (measles, mumps, rubella).
Combined shot (date given): MMR #1 __/__/__ MMR #2 __/__/__ **OR** Titer showing immunity date: __/__/__ Results: _____

B. HEPATITIS B

Hepatitis B is a serious viral infection that can lead to chronic liver disease, liver cancer, liver failure and even death. It is contracted through exposure to infected blood and through body fluids that may contain blood. This disease is preventable by vaccination. A series of three (3) doses of the vaccine are required for optimal protection. Missed doses may still be sought if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

REQUIRED for student pharmacists and nursing students. ALL other students must provide proof of vaccination **OR** waiver below.
Hepatitis B (HBV) immunization (date given): #1 __/__/__ #2 __/__/__ #3 __/__/__

❏ I decline receipt of vaccine to protect for Hepatitis B. **Student's Signature** _____
Parent/Guardian Signature (if student is not 18 years of age) _____

C. MENINGITIS

Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococcemia (bacteria in the blood). College students, especially freshmen living in residence halls, are at an increased risk for contracting meningococcal disease. The bacterial form of this disease can lead to serious complications such as swelling of the brain, coma, loss of limbs and even death in a short period of time. The disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. Immunization can prevent up to 80% of meningococcal meningitis in the United States and for the majority of the cases in the university population. The vaccine is considered safe and effective against 4 of the 5 types of bacteria responsible for meningococcal meningitis. For more information regarding meningitis go to www.musa.org.

Vaccination **OR** waiver REQUIRED for ALL students living in a residential hall.
Meningitis vaccine (date given): __/__/__

❏ I decline receipt of vaccine to protect for meningococcal. **Student's Signature** _____
Parent/Guardian Signature (if student is not 18 years of age) _____

D. VARICELLA

As of July 2011, the State of Tennessee requires ALL students born after 1979 to have documented date of chickenpox disease **OR** two (2) varicella vaccinations **OR** proof of immunity by positive IgG titer. Student pharmacists and dietetic interns MUST show immunity with a titer.
Date of disease: __/__/__ **OR** Two (2) Varicella immunizations (date given): #1 __/__/__ #2 __/__/__ **OR** Titer showing immunity date: __/__/__

E. TUBERCULOSIS (TB) SCREENING (Must be within 12 months prior to enrollment).
Option 1 **OR** 2 is REQUIRED for ALL NEW students and Option 1 is REQUIRED for student pharmacists and dietetic interns.

Option 1: PPD (TB skin test) or Interferon Gamma Release Assay (IGRA)
Date given: __/__/__ Given by (initials): _____ Date read: __/__/__
Results: PPD: ____ mm of induration **OR** IGRA: ❏ positive ❏ negative ❏ intermediate

Option 2: Fill out the TB Assessment Form (separate form) and sign the bottom. If you have risk factors, an appropriate TB screening test is necessary.

F. TETANUS

Suggested for ALL NEW students and REQUIRED for student pharmacists and nursing students.
Date given (within past 10 years): __/__/__ circle one: Td Tdap

I certify that this student has had the immunizations above.

Health Care Provider Signature: _____ **Date:** _____

Printed name: _____ Phone: _____