University of Lynchburg

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Standard Health Form 2019

Please Print

Name:_____ **DOB:**_____
Last **First** **MI**

Phone #:_____University Email:_____

Home Address:_____City:_____State:_____Zip Code:_____

Local Address:_____City:_____State:_____Zip Code:_____

Birthdate: Month/Day/Year:_____Age:_____Gender: _____Marital Status: _____

Emergency Contact:_____Emergency Contact #:_____

Family Physician's Name:_____Phone #:_____

Physician Address:_____

INSURANCE

All students are expected to have health insurance coverage while attending University of Lynchburg. The University cannot protect students from the consequences of being uninsured.

Name of Insurance Company:_____ID/Group #:_____

Individual/Employee ID #:_____

MEDICAL CONDITIONS

Please list all major medical conditions:

_____

_____

MEDICATIONS

If you take any medications orally or by injection on a frequent or regular basis, list and indicate dosage and frequency:_____

_____

ALLERGIES

Do you have any allergies to medications? _____Yes _____ No

Specify:_____

Other Allergies: _____

University of Lynchburg- Medical History

Name:_____ **DOB:**_____

Last **First** **MI**

PERSONAL MEDICAL HISTORY:

CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING:

___ Cancer
___ Heart Murmur
___ High Blood Pressure
___ Asthma/Bronchitis/Pneumonia
___ Frequent Colds/ Sinus Infections
___ Ear Infections/Hearing Loss
___ Mononucleosis
___ Anemia/Blood Disorder
___ Sickle Cell Trait
___ Dizzy Spells
___ Eating Disorder
___ Obesity

___ Chronic Headaches/Migraines
___ Head Injury/Concussion
___ Back/Joint Injuries
___ Broken Bones
___ MRSA Infection
___ Arthritis
___ Anxiety/Depression
___ Mental Health Issues
___ ADD/ADHD
___ Drug Addiction/Alcoholism
___ Chicken Pox
___ Other _____

___ Thyroid Disorder
___ Diabetes
___ Irritable Bowel/Spastic
___ Stomach Ulcer
___ Hepatitis
___ Recurrent Bladder Infections
___ Kidney Problems
___ Menstrual Problems
___ Abnormal Pap Smear
___ Epilepsy/Seizure Disorder

Details of above: _____

_____

Do you have a physical disability? _____ If yes, explain any special services needed: _____

_____

List any serious illness, injury, hospitalization, or surgeries: _____

_____

FAMILY HEALTH HISTORY

INDICATE ANY PRESENT OR PAST HEALTH CONDITIONS IN PARENTS, SIBLINGS OR CHILDREN:

ILLNESS	FAMILY MEMBER	ILLNESS	FAMILY MEMBER
Hypertension/BP	_____	Seizure/Neurological Disorder	_____
Heart Disease	_____	Asthma	_____
Heart Rhythm Problems	_____	Anxiety/Depression	_____
Cancer	_____	Alcohol/Drug Problems	_____
Stroke	_____	Tuberculosis	_____
Diabetes	_____		

Does anyone in your immediate family suffer from other serious health problems?_____Explain:_____

_____

_____

Number of siblings: _____ List any deceased parents and siblings with cause of death:_____

_____

I certify that the information I have provided on this form is truthful, accurate and complete to the best of my knowledge. I understand it will be used only by Lynchburg Health Services and will be maintained as confidential information in my student health record. This information will not be released without my written consent, except in cases of life threatening emergencies. I also understand that information on this form is intended for medical services only.

Signature of Student (required) :_____ Date: _____

Consent for the Treatment of Minors (Students 17 years and younger)

University of Lynchburg Health Services has my permission to treat my minor child in the event of a medical emergency. University of Lynchburg Health Services also has my permission to treat my child for routine medical care, including check-ups, immunizations, and/or treatment for minor injuries and illness.

Signature of Parent or Guardian: _____ **Date:** _____

University of Lynchburg - Immunization Record

(Must be completed, signed and dated by a licensed healthcare professional)

Name:_____ **DOB:**_____

Last **First** **MI**

REQUIRED IMMUNIZATIONS/TITERS (Month/day/year)

1. MMR (Measles, Mumps, Rubella) **OR** TITER (Two doses live vaccine at or after 12 months of age, at least 1 month apart)

Dose #1 _____/____/_____
Dose #2 _____/____/_____

Titer results	Measles	Negative	Positive
	Mumps	Negative	Positive
	Rubella	Negative	Positive

Titer Date_____/____/_____

2. DIPHTHERIA/PERTUSSIS/TETANUS (TDap) (Booster within last 10 years) Date _____/_____/_____

3. MENVEO/MENACTRA (ACWY) VACCINE (Dose after 16th birthday) Date _____/____/_____

4. HEPATITIS B VACCINE **OR** TITER (Series of 3 vaccines)

Dose #1 _____/____/_____
Dose #2 _____/____/_____
Dose #3 _____/____/_____

Titer results Negative Positive Titer Date ____/____/_____

5. VARICELLA VACCINE **OR** TITER (Two doses of vaccine one month apart)

Dose #1 _____/____/_____
Dose #2 _____/____/_____

Titer results Negative Positive Equivocal Titer Date ____/____/_____

RECOMMENDED IMMUNIZATIONS

A. HEPATITIS A VACCINE

Dose #1 _____/____/_____
Dose #2 _____/____/_____

B. HUMAN PAPILLOMAVIRUS VACCINE (HPV)

Dose #1 _____/____/_____
Dose #2 _____/____/_____
Dose #3 _____/____/_____

C. POLIO VACCINE -COMPLETED CHILDHOOD SERIES Last dose _____/____/____

D. BEXSERO/TRUMENBA (MEN B)

Dose #1 _____/____/_____
Dose #2 _____/____/_____

Medical Exemption_____ Religious Exemption_____(Notarized letter must be submitted)

Verified by: Healthcare Provider's Signature_____

Provider's Name Printed_____

Address_____

Phone_____

University of Lynchburg - Tuberculosis Screening

(Must be completed, signed and dated by a licensed healthcare professional)

Name:_____ **DOB:**_____
Last **First** **MI**

A. Has the patient ever had a positive reaction to a TB skin test? No Yes*
*Documentation of, chest x-ray, and treatments required. See Tuberculosis Testing page.

B. Does the patient have any of the following symptoms of active TB disease?

Fever	No	Yes
Unexplained weight loss	No	Yes
Loss of appetite	No	Yes
Night sweats	No	Yes
Chronic cough	No	Yes
Coughing up blood	No	Yes
Chest pain	No	Yes

C. Do any of these high-risk categories apply to the patient?

Known exposure to HIV infection	No	Yes
Recent contact with someone infected with TB	No	Yes
History of illicit drug use	No	Yes
Resided or worked in homeless shelter, prison, nursing home,hospital, or other health care facility	No	Yes
History of silicosis, diabetes, renal disease, blood disorders or cancer	No	Yes
Low body weight	No	Yes
Gastric bypass	No	Yes
Prolonged corticosteroid or other immunosuppressive therapy	No	Yes

Within the past 5 years traveled to or lived in any of the following countries? No Yes

Angola	Azerbaijan	Bangladesh	Belarus Botswana	Brazil
Cambodia	Cameroon	Chad	China	Congo
Central African Republic	DPR Korea	DR Congo	Ethiopia	Ghana
India	Guinea-Bissau	Indonesia	Kazakhstan	Kenya
Kyrgyzstan	Lesotho	Liberia	Malawi	Mozambique
Myanmar	Namibia	Nigeria	Pakistan	Papua
New Guinea	Peru	Philippines	Sierra Leone	
Republic of Moldova	Somalia	South Africa	Swaziland	Tajikistan
Thailand	Russian Federation	Uganda	Ukraine	Uzbekistan
Viet Nam	Zambia	Zimbabwe	United Republic of Tanzania	

Reviewed by: _____**RN/LPN/NP/MD**

Date:_____

IF "YES" TO ANY QUESTIONS IN SECTIONS B or C ABOVE, PROCEED TO TUBERCULOSIS TESTING

University of Lynchburg - Tuberculosis Testing

(Must be completed, signed and dated by a licensed healthcare professional)

Name:_____ **DOB:**_____
Last **First** **MI**

Students with positive screening must undergo either Tuberculin Skin Test OR Interferon Gamma Release Assay Test within 6 months prior to the start of the semester.

Option 1: Tuberculin Skin Test (TST)

The TST result should be recorded as actual 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.*

PPD (Mantoux) 0.1ml intradermally left/right forearm Lot #:_____ Exp. date:_____

Date placed:_____Time placed:_____Placed by:_____(RN/NP/PA/MD)

Date read:_____Time read:_____Read by:_____(RN/NP/PA/MD)

Result: _____mm induration *Interpretation: Negative:_____Positive:_____

***>5mm is positive:**

- Recent close contact with an individual with infectious TB
- Persons with fibrotic changes on prior chest X-ray, consistent with past TB disease
- Organ transplant recipients and other immunosuppressed persons including HIV infected persons

***>10mm is positive:**

- Recent arrivals to the US (<5 years) from high prevalence areas or who resided in one for a significant amount of time
- Injection drug users
- Mycobacteriology laboratory personnel
- Residents, employees or volunteers in high risk congregate settings
- Persons with medical conditions that increase the risk of progression to TB disease

***>15mm is positive:**

- Persons with no known risk factors for TB

Option 2: Interferon Gamma Release Assay (IGRA)

Date blood drawn:_____ Method: QFT-GIT_____T Spot_____Other_____

Result: Negative_____ Positive_____
Indeterminate_____ Borderline (T Spot only)_____
Indeterminate or borderline results not acceptable. Repeat test.

Chest X-ray: Required if TST or IGRA is positive. Please attach a copy of the report.

Date:_____ Result: _____Normal _____Abnormal

Treatment for TB disease or Latent TB:

Completed_____ Ongoing_____ Dates of treatment regimen: from_____ to _____

Healthcare Provider's Signature_____

Provider's Name Printed_____

Address_____

Phone_____