PROVIDENCE COLLEGE | STUDENT HEALTH CENTER

DUE DATE
January 7, 2019

One Cunningham Square
Bedford Hall
Providence, RI 02918-0001
401-865-2422

PERSONAL & CONFIDENTIAL
PLEASE PRINT OR TYPE

Name: _____
Last First MI

Class Year: 20_____ Date of Birth: _____ Banner ID #: 00_____

Home Address: _____
Street City State Zip

Home Phone: _____ Student Cell Phone: _____

Mother's Name: _____ Mother's Cell/Work: _____

Father's Name: _____ Father's Cell/Work: _____

HEALTH INSURANCE COVERAGE: YOU MUST INCLUDE A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD WITH THIS FORM.

It is the responsibility of each student to understand the requirements of his/her medical coverage.

1. Does your insurance coverage require pre-authorization: ☐ YES ☐ NO
2. Does your insurance company cover you in the State of Rhode Island? ☐ YES ☐ NO

Insurance Carrier: _____ Phone: _____

Address: _____
Street City State Zip

Policy Number: _____ Group #: _____

Name of Principal Insured: _____ Employer of principal insured: _____

HAVE YOU APPLIED FOR INSURANCE COVERAGE THROUGH UNIVERSITY HEALTH PLANS? ◯ YES ◯ NO

If yes, your membership card will be available online for you to print and carry after the start of the 2018-19 academic year.

EMERGENCY CONTACTS

_____
Name Address

_____
Phone Relationship to Student

_____
Name Address

_____
Phone Relationship to Student

Student Name:_____ Date of Birth: _____

AUTHORIZATION FOR TREATMENT: *(Please read and sign below)*

The Student Health Center shares information on the Health Form with the on-campus Personal Counseling Center on a need-to-know basis.

I hereby authorize the Providence College Student Health Center and Personal Counseling Center to hospitalize and/or provide medical/psychiatric treatment and services as it deems appropriate. This authorization will remain in effect as long as I am a student at Providence College.

Student Signature:_____Date: _____

(For students under 18 years of age)
Signature of Parent or Guardian:_____Date: _____

Student Name:_____ Date of Birth: _____

ALLERGY & MEDICATION INFORMATION *(Please list **ALL**)*

Do you require the use of an epi-pen? ◯ YES ◯ NO

IF YES, YOU MUST HAVE TWO EPI-PENS ON-CAMPUS AND ONE SHOULD BE CARRIED WITH YOU AT ALL TIMES.

Medication Allergies: _____

Food Allergies: _____

Are you presently on any medications? ◯ YES ◯ NO *If yes, please list **ALL** below:*

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

FAMILY HISTORY

	AGE	CURRENT HEALTH STATUS	IF DECEASED, AGE	CAUSE
FATHER				
MOTHER				
SIBLINGS				

Please answer the following questions relating to your past and present medical history. When in doubt, clarify this history with your family and/or provider.

HOSPITALIZATION/SURGERY

Have you ever been hospitalized or had surgery? ◯ YES ◯ NO *If yes, please explain below:*

HOSPITAL	REASON	DATE

PERSONAL HISTORY

Please check each box:	YES	NO		YES	NO		YES	NO
Anemia			Fainting (frequent)			Neurological Disease		
Anxiety			Fractured Bones			Pneumonia		
Arthritis			Gastrointestinal Disorder			Rheumatic Fever		
Asthma			Gyn Exam			Seizure Disorder (Epilepsy)		
Back Problems			Head Injury			Skin Disease		
Blood Disease			Headaches (frequent)			Substance Misuse		
Colitis			Hearing Loss			Thyroid Disease		
Counseling			Heart Disease/Murmur			Tropical Disease/Parasites		
Crohn's Disease			Hernia			Tuberculosis		
Deformities of Bones/Joints			High Blood Pressure			Ulcer Disease		
Dental			Jaundice			Urinary Tract Infections		
Depression			Kidney Disease			Viral Hepatitis		
Diabetes			Liver Disease			Visual Impairment		
Ear Infections (recurrent)			Lung Disease			Weight Loss or Gain		
Eating Disorders			Lyme Disease			Other		
Endocrine Disease			Mononucleosis Date:					
Eye, Ear, Nose, Throat Disorder			Muscular Disease					

Student Name:_____Date of Birth: _____

IMMUNIZATION RECORD Please supply EMR vaccination or have your at home provider fill out and sign below.

REQUIRED IMMUNIZATIONS

Hepatitis B 3 doses required	Date of Dose #1:	Date of Dose # 2:	Date of Dose #3:
or **Hepatitis B Titer**	☐ pos ☐ neg - attach report Date:		
MMR (Measles, Mumps, Rubella) 2 doses required or individual vaccines as listed below	Date of Dose #1: Given at 12 months after birth or later	Date of Dose #2: Given at least 1 month after first dose	
Measles (Rubeola) Students born prior to 1957 are required to have at least one dose	Date of Dose #1:	Date of Dose #2:	or Record of Titer -attach report ☐ pos ☐ neg Date:
Mumps Required for all students regardless of age	Date of Dose #1: Immunized with live vaccine at 12 months after	Date of Dose #2: Given at least 1 month after the first dose	or Record of Titer –attach report ☐ pos ☐ neg Date:
Rubella (German Measles) Required for all students regardless of age	Date of Dose #1: Immunized with live vaccine at 12 months after	Date of Dose #2: Given at least 1 month after the first dose	or Record of Titer – attach report ☐ pos ☐ neg Date:
Meningococcal Vaccine (A, C, Y, W-135) Required if under 22 years old	☐ Menactra ☐ Menomune ☐ Menveo ☐ Other:	Date of Dose #1	Date of Booster Dose: **Required if dose 1 was given before 16 years old**
Tdap (Tetanus-Diphtheria- Pertussis) Must be within the past 10 years	Date of Dose:		
Varicella (Chicken Pox) History of disease or 2 doses required or positive titer	Date of Dose # 1: Date of Dose # 2:	or History of Disease Date:	or Record of Titer – attach report ☐ pos ☐ neg Date:

OTHER IMMUNIZATIONS

Hepatitis A	Date of Dose #1:	Date of Dose #2:	
HPV (indicate HPV-4 or HPV-9)	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:
Meningococcal B Vaccine (Trumenba or Bexsero)	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:
Polio (most recent booster)	Date:		
Rabies	Date of Dose #1:	Date of Dose #2:	Date of Dose #3:
Typhoid	Date:	☐ Oral ☐ Injectable	
Other (Flu, Pneumovax, Yellow Fever, Japanese Encephalitis)			

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Address: _____
Street City State Zip

Phone:_____Fax: _____

Student Name:_____ Date of Birth: _____

FOR YOUR PROVIDER: *Please review patient's personal history (pg. 3) and TB screening (pg. 6) before completing physical exam. Please date and sign below or supply EMR.*

Past Medical History: _____

Current Meds/Therapies: _____

Physical Limitations: _____

Blood Pressure:_____Pulse:_____Height:_____Weight: _____

VISION: DISTANCE R_____ L_____ BOTH _____

CORRECTED ◯ NOT CORRECTED ◯

GLASSES ◯

CONTACTS ◯

	NORMAL	ABNORMAL		NORMAL	ABNORMAL
HEENT			BACK		
NODES			MS		
CV			NEURO		
RESP			SKIN		
ABD			GU/GYN		

Comments: _____

_____

_____

SUMMARY OF EXAMINING PROVIDER

Is this student receiving or does he/she require continuing medical care, therapy or observation?

YES ◯ NO ◯ *If yes, please explain:*

_____

_____

On the basis of the foregoing Medical History and Physical Examination, should restrictions be imposed on physical activity?

YES ◯ NO ◯ *If yes, please explain:*

_____

_____

From the standpoint of physical and mental health, do you have any reservations about the advisability of this individual's plans for his/her college years?

YES ◯ NO ◯ *If yes, please explain:*

_____

_____

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Address: _____

Street City State Zip

Phone:_____

Fax: _____ Date of Exam: _____

Student Name:_____ Date of Birth: _____

TUBERCULOSIS (TB) SCREENING FORM – **STUDENT** and **PROVIDER'S** signatures required.

To help us determine if you need to have a TB (Tuberculosis) skin test before coming to Providence College, you must answer the following questions and provide your signature/appropriate documentation at the end of the section.

1. Were you born in one of the following areas: Africa, Asia, Philippines, Indonesia, Eastern Europe, Latin America, Mexico, Portugal, Caribbean, or the Middle East?	YES ☐ NO ☐
2. Have you lived in or had extensive travel to a high prevalence area (listed above)?	YES ☐ NO ☐
3. Have you worked or lived in a potentially high risk setting such as a prison, a long term care facility, a homeless shelter, a residential facility for persons with HIV/AIDS or a drug treatment center?	YES ☐ NO ☐
4. Have you had recent close or prolonged contact with someone with infectious TB?	YES ☐ NO ☐
5. Do you or anyone living in your household have a history of intravenous or other street drug use, or HIV infection/AIDS?	YES ☐ NO ☐
6. Have you ever had a documented positive TB skin test or history of active TB infection?	YES ☐ NO ☐

*If you answered **No** to all of the above questions (1 – 6), no further testing or further action is required. Please sign below, and send this form with your immunization record to Health Services.*

*If you answered **Yes** to any of the first 5 questions and **No** to question 6, then you are required to have a PPD skin test or TB blood test (IGRA, TB Quantiferon Gold, TB-spot) within 6 months prior to the start of classes. The PPD skin test or IGRA **must be performed in the U.S.** Please sign below and have your provider document the results of your testing.*

*International students who are **unable** to have either the PPD skin test or IGRA done in the US, will need to have the testing performed at Health Services within one month of starting at Providence College. Please call 401-865-2422 or email the Director (ckellehe@providence.edu) **before** September 7, 2018 to request an appointment for PPD.*

*If you answered **Yes** to question 6, then you do not need to be retested, but must provide documentation of a negative chest x-ray done in the U.S (within 6 months prior to the start of classes), and documentation of any medication and treatment for your positive TB test. Please include documentation with this form and sign form below.*

***Student Signature**:_____**Date:**_____*

TB (TUBERCULIN) SKIN TEST: Must be performed in the U.S. *(International students who are unable to have the test done in the U.S., will need a TB skin test at Health Services within 1 month of starting at Providence College.)*

Date TB Skin Test Given: _____

Date TB Skin Test Read (within 48-72 hours): _____

Results *(must be recorded in mm of induration; if no induration, write "0"):*_____mm

IGRA must be performed in the U.S.: TB Quantiferon Gold ◯ TB spot ◯

Result: Positive ◯ Negative ◯ Indeterminate ◯

Chest X-ray *(Required if tuberculosis test is positive):* Date:_____

Result: Normal ◯ Abnormal ◯

Dates of Treatment for Latent or Active TB: _____

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Phone: _____ Fax: _____