

The Wellness Center
100 Campus Circle
Owings Mills, MD 21117-2857
443-352-4200 Fax: 443-352-4201

OFFICE USE ONLY:				
REVIEWED	COMPLETE	NUESOFT	DATATEL	IMMUNIZED FROM CLASSE

Student ID #: _____
(if available)
 Resident Commuter

STUDENT HEALTH FORM

THIS STUDENT HEALTH FORM MUST BE COMPLETED BY ALL NEW FULL-TIME RESIDENTIAL AND COMMUTER STUDENTS. IF IN THE PREVIOUS SEMESTER YOU WERE A PART-TIME STUDENT AND YOU ARE NOW TAKING 12 OR MORE CREDITS, YOU MUST COMPLETE THIS STUDENT HEALTH FORM. Allow 4-6 weeks to complete this form if a healthcare visit is needed. Failure to submit a complete Student Health Form will block you from registering for future classes and/or lead to removal from housing.

DUE: AUGUST 1st (Fall admission) January 2nd (Spring admission) *Must be postmarked on these dates if mailed.

GENERAL INFORMATION

Name: _____			Social Security No. (Last Four Digits): _____	
Last	First	Middle		
Address: _____			City _____ State _____ Zip Code _____	
Home Phone: _____			Student Cell Phone: _____	
Including Area Code			Including Area Code	
Date of Birth: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Varsity Athletic Sport (if any) _____		
Mo. / Day / Year				
Initial Term Entering SU as a Full-time student: <input type="checkbox"/> Fall _____ <input type="checkbox"/> Spring _____		Circle one: FR SO JR SR _____		
Year Year		Previous college/university (if any)		
Student personal email address(es): _____				

MAKE COPIES OF YOUR STUDENT HEALTH FORM FOR YOUR OWN RECORD. WE CANNOT GUARANTEE THE ARRIVAL OF MAILED FORMS.

SUBMIT COMPLETED FORMS BY ONE OF THE FOLLOWING WAYS:

- Mailing: Stevenson University Wellness Center, 100 Campus Circle, Owings Mills, MD 21117
 - Drop off: Caves Sports & Wellness Center (Owings Mills Campus) 10945 Boulevard Circle, Owings Mills, MD 21117
 - Fax: 443-352-4201 *You **do not** need to submit originals of the Student Health Form if you fax a copy.*
 - Email: StudentHealthForm@stevenson.edu Please Label the Subject Line: *Last Name, First Name – Student ID (if available)*
- Please note: As required by law, we are committed to protecting the privacy and security of your health information. By sending your records via email, you understand that information transmitted is not considered secure and as a result, confidentiality cannot be guaranteed. We make every effort to keep your information confidential.*

ALL STUDENT ATHLETES MUST PROVIDE A COPY OF THEIR PHYSICAL EXAM TO THE ATHLETIC TRAINING DEPARTMENT ALONG WITH YOUR COMPLETED ATHLETIC TRAINING PAPERWORK (Due: 7/27 Note- This is an earlier due date for Athletic purposes) Phone: 443-352-4269 Fax: 443-352-4265 Mailing address: Athletic Training Dept., 100 Campus Circle, Owings Mills, MD 21117

ALLOW 3-5 business days for your records to be received, reviewed and processed after submitting.

***CHECK THE STATUS OF YOUR STUDENT HEALTH FORM COMPLIANCE: Go to WebExpress →click "Forms"→ click "Missing Information"**

RETURNING STUDENT?

If you already submitted a Student Health Form in the past, you **do not** need to submit another Student Health Form each year unless you haven't been a Stevenson University student for at least 2 years and you are reapplying for admission to Stevenson University as a full-time student. In this case, you *will* need to complete another Student Health Form.

HOW TO OBTAIN IMMUNIZATION RECORDS:

Examples: Primary care physician, high school, previous college/university

- If you are unable to locate vaccination records, you can have blood work drawn to obtain titer results which proves protected status. Contact your primary care physician, a local care clinic, or the Wellness Center to obtain a physician's order.

TURNING IN OTHER HEALTH INFORMATION FOR ATHLETIC, NURSING, MEDICAL TECHNOLOGY DEPARTMENTS, ETC.?

THE WELLNESS CENTER STILL NEEDS YOU TO COMPLETE A STUDENT HEALTH FORM IF YOU HAVE NOT ALREADY.

IS HEALTH INSURANCE REQUIRED?

No. The Wellness Center does not accept health insurance. We bill the students account. The Wellness Center can print receipts which you can submit to your insurance company. Students are encouraged to retain health insurance and carry their card with them (for referrals, lab testing, etc.). Unfortunately, at this time we are not offering a university health insurance plan. Consider the following:

- Check with your parent/guardian to see if you can remain on their policy
- American College Student Association: 1-888-488-2272 or 1-888-526-2272

_____ Last Name _____ First Name MI _____ DOB _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____
 Home Phone: _____ Including Area Code Work Phone: _____ Including Area Code Cell Phone: _____ Including Area Code

CONSENTS – RELEASE OF MEDICAL INFORMATION / COMMUNICATION / PARENTAL CONSENT FOR MEDICAL TREATMENT OF MINOR

These authorizations will expire once the student withdraws/graduates from Stevenson University.

1. I hereby authorize Stevenson University to **disclose information on the health forms to any Health Care Provider who has rendered medical services to me.**
 _____ Date _____ Date _____
 Student Signature Signature of Parent/Guardian (if student is under 18 years of age)

2. I hereby authorize Stevenson University Wellness Center to **discuss information regarding my Student Health Form with** _____ (name of individual) who is my _____ (relationship).
 _____ Date _____
 Student Signature (if student is older than 18 years of age)

3. I hereby authorize the Stevenson University Wellness Center to **disclose pertinent information regarding my Student Health Form and release information to the Athletic Department pertaining to my ability to participate in athletic activity.**
 _____ Date _____ Date _____
 Student Signature Signature of Parent/Guardian (if student is under 18 years of age)

4. I hereby authorize the Stevenson University Wellness Center to **leave detailed messages on my voicemail/email regarding information on my Student Health Form**, as missing information may prevent me from moving on campus and/or registering for future classes.
 _____ Date _____ Date _____
 Student Signature Signature of Parent/Guardian (if student is under 18 years of age)

5. **PARENTAL CONSENT FOR MEDICAL TREATMENT OF MINOR** (Younger than 18 upon arrival on campus):
 I hereby authorize my son/daughter **to be treated in the Stevenson University Wellness Center. In case of emergency and in the event that I am unavailable, the student is permitted to be taken to the nearest emergency care center or hospital for treatment. I authorize my health insurance to be used for medical treatment (if applicable).**
 _____ Date _____
 Signature of Parent/Guardian (if student is under 18 years of age)

PERSONAL MEDICAL HISTORY

<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Head injury/concussion	<input type="checkbox"/> Irritable bowel syndrome
<input type="checkbox"/> Anorexia/Bulimia	<input type="checkbox"/> Celiac Disease	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Migraine
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Peptic ulcer disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Bronchitis (Chronic)	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Infectious Mono	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> None of the above			

CURRENT ILLNESSES OR CONDITIONS
 Illness/Condition: _____ Year Diagnosed: _____
 Current Treatment: _____

HOSPITALIZATION OR MAJOR SURGERIES: _____

MEDICATIONS: List all medication taken on a regular or frequent basis. Please include birth control pills and nonprescription drugs.
 Drug: _____ Dose: _____ Drug: _____ Dose: _____
 Drug: _____ Dose: _____ Drug: _____ Dose: _____

ALLERGIES: **None**
 Drug allergies (specify): _____
 Other allergies (specify): _____
 Does patient carry an Epi-Pen? Yes / No (Please circle)

INSURANCE CARD INFORMATION

Attach a copy of your insurance card (BOTH FRONT AND BACK OF CARD) _____ Please check if you do NOT have health insurance
 Health insurance company: _____ Policy Number: _____
 Policy Holder's Name: _____

Last Name

First Name

MI

DOB

TUBERCULOSIS RISK ASSESSMENT

Please complete the following form in its entirety. Place a checkmark in the box in front of the section if any item in the section is true for the student. **IF YOU CHECK ANY OF THE BOXES IN SECTIONS 1-4 YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST.** A HISTORY OF BCG VACCINATION SHOULD NOT PRECLUDE TESTING OF A MEMBER OF HIGH-RISK GROUP. Check "No" if sections 1-4 do not apply to patient.

- Section 1: Check this box if the patient has any of the following **POSSIBLE SYMPTOMS OF TUBERCULOSIS**:
 - Unexplained weight loss
 - Unexplained elevation of temperature for more than one week
 - Unexplained night sweats
 - Unexplained persistent cough for more than 3 weeks
 - Unexplained cough productive of bloody sputum
- Section 2: Check this box if patient has had any of the following **RISK FACTORS FOR TUBERCULOSIS INFECTION**:
 - Close contact with a known case of active tuberculosis
 - Use of illegal injected drugs
 - HIV (Human Immunodeficiency Virus) Infection
 - Health Care Worker
 - Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)
- Section 3: Check this box if you have any of the following **RISK FACTORS FOR TUBERCULOSIS DISEASE**:
 - Diabetes mellitus
 - Lymphoma, leukemia or cancer of the head, neck or lung
 - Chronic kidney failure
 - Silicosis
 - Gastrectomy or jejunio-ileal bypass
 - Greater than 10% below ideal body weight
- Section 4: Check this box, if in the last five years, you have lived in or traveled for 30 days or more to any of the following **Areas with a High Relevance of Tuberculosis** as defined by the World Health Organization and the state health department:
 - Africa** – All countries
 - Asia/Southeast Asia/Pacific Island** – All countries
 - North, Central & South America** – Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
 - Europe** – Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
 - Middle East** – Bahrain, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

Are any of the boxes checked in Sections 1-4 of the Tuberculosis Risk Assessment?

- No.
- Yes. PPD skin testing is required (please see below).

1. Tuberculin Skin Test (PPD)

Date Given (Mo./Day/Yr.)	Date Read (Mo./Day/Yr.)	Result (Record actual mm of induration; transverse diameter; if no induration, write "0")	Interpretation (based on mm of induration as well as risk factors) (Please circle)
		_____mm	Positive / Negative

2. If greater than 10 mm induration, chest x-ray required.

Date of chest x-ray (Mo./Day/Yr.)	Result (Please circle)	Attach copy of chest x-ray report if abnormal (check)
	Normal / Abnormal	

3. Document any treatment patient has received for either a positive TB skin test or active tuberculosis.

Medication(s) received: _____

Date Started (Mo./Day/Yr.)	Date Completed (Mo./Day/Yr.)

Last Name
MY STUDENT BODY

First Name MI

DOB



Please allow 90 minutes to complete the required online **Essentials chapters- Alcohol, Drugs and Sexual Violence**
*If you do not already have your SU email, you will receive this during your orientation.

MyStudentBody is an exciting, interactive educational web based program concerning wellness for Stevenson University students and parents. **All residential students and first year commuters are required to complete the Essentials chapters- Alcohol, Drugs and Sexual Violence.** If in the previous semester, you were a part-time student and are now taking 12 or more credits or if you are a transfer student from another college/university and are not a residential student – you are exempt from providing a certificate of completion. The Wellness Center encourages all students to use the resources of www.mystudentbody.com for a variety of wellness issues.

Instructions:

Please go to www.mystudentbody.com and click **“Register Now”** on the right hand side of the screen. The school code is **sumustangs**, enter your username as your **SU email address** and the password as your **SU password**. After logging in, click **“Take Now”** below **“Essentials”** on the left hand side of the screen. Complete the rate myself questionnaire, take the pre-test, review the course material and then take the post- test for all essential chapters. *****Please attach the certificate of completion to this Student Health Form.**

____ Check to confirm certificate is attached to the Student Health Form ____ Check if you are exempt based on previous criteria

YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET UNIVERSITY REQUIREMENTS. THE FOLLOWING MEDICAL INFORMATION MUST BE EITHER:

- **COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER**
- OR**
- **MEDICAL DOCUMENTS MUST BE ATTACHED TO THIS STUDENT HEALTH FORM**

IMMUNIZATIONS AND SKIN TESTING

RECOMMENDED	Dose 1	Dose 2	Dose 3
Tetanus (most recent) <i>*Recommended after 5 years</i>	___/___/___ Mo. Day Yr.		
Quadrivalent Human Papillomavirus Vaccine (HPV)	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.
Hepatitis B Series	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.
Surface Antibody Titer (copy of lab results should be attached if vaccination records are not available) Date: ___/___/___ Immune: ___ Yes ___ No *If non-immune, student should get booster. Mo. Day Yr.			

REQUIRED STUDENTS MUST PROVIDE PROOF OF EITHER HISTORY OF DISEASE, VACCINATIONS, OR POSITIVE TITER.	History	Dose 1 (12 months after birth or later)	Dose 2 (Any time 1 month after dose #1)	Dose 3 *Only necessary if non-immune after titer <i>or</i> if previous doses were administered before CDC immunization schedule	Titer *copy of positive lab result must be attached
Varicella (Chicken Pox)	___/___ Mo. Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.
Measles, Mumps, Rubella (MMR)	___ check here if born before 1957 and considered immune	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.	___/___/___ Mo. Day Yr.

PPD (Please see page 3 to see if student requires a PPD test).

Last Name

First Name

MI

DOB

***REQUIRED FOR STUDENTS RESIDING ON CAMPUS *RECOMMENDED FOR COMMUTERS**

Meningococcal Vaccine Requirement Check here if student intends to live on campus.
(Health-General Article 18-102(b) Annotated Code of Maryland and Code of Maryland Regulations (COMAR) 10.06.05 Meningococcal Vaccination Requirements for Students in Institutions of Higher Education). **If the primary dose of meningitis was administered before the students 16th birthday, a booster will be required before moving into residence on campus AND the meningitis vaccination must not be older than 5 years from the date of move-in.**

Date Received: ___/___/___ Mo. Day Yr.	MCV4 Vaccine (Menactra or Menveo) MenACWY-CRM *PREFERRED	MPSV4 Vaccine (Menomune)
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Maryland Department of Mental Health and Hygiene

http://www.dmd.state.md.us/comar/comarhtml/13/10.06.05.02.htm

10.06.05.02

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Enrolled" means having registered for a credit or noncredit course.

(2) "Institution of higher education" means a school of post-secondary education that generally limits enrollment to graduates of secondary schools and awards degrees at the associate, baccalaureate, or graduate level.

→ (3) "Meningococcal vaccination" means receipt of the vaccine protecting against at least the four serogroups of A, C, Y, and W-133 of meningococcal disease within the preceding 3 years before the individual moves into on-campus student housing.

(4) "On-campus student housing" means housing provided to individuals, regardless of the fee, that is owned, rented, or contracted for and operated by an institution of higher education, or through written agreement, with an agent of the institution of higher education.

Centers for Disease Control and Prevention

http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5003a2.htm

Recommendation for Routine Vaccination of Persons Aged 11 Through 18 Years

→ ACIP recommends routine vaccination of persons with quadrivalent meningococcal conjugate vaccine at age 11 or 12 years, with a booster dose at age 16 years. After a booster dose of meningococcal conjugate vaccine, antibody titers are higher than after the first dose and are expected to protect adolescents through the period of increased risk through age 21 years. For adolescents who receive the first dose at age 13 through 15 years, a one-time booster dose should be administered, preferably at age 16 through 18 years, before the peak in increased risk. Persons who receive their first dose of meningococcal conjugate vaccine at or after age 16 years do not need a booster dose. Routine vaccination of healthy persons who are not at increased risk for exposure to *N. meningitidis* is not recommended after age 21 years.

Recommendation for Persons Aged 2 Through 54 Years with Reduced Immune Response

Data indicate that the immune response to a single dose of meningococcal conjugate vaccine is not sufficient in persons with certain medical conditions. Persons with persistent complement component deficiencies (e.g., C5–C9, properdin, factor H, or factor D) or asplenia should receive a 2-dose primary series administered 2 months apart and then receive a booster dose every 5 years. Adolescents aged 11 through 18 years with HIV infection should be routinely vaccinated with a 2-dose primary series. Other persons with HIV who are vaccinated should receive a 2-dose primary series administered 2 months apart. All other persons at increased risk for meningococcal disease (e.g., microbiologists or travelers to an epidemic or highly endemic country) should receive a single dose.

CDC Guidance for Transition to an Adolescent Booster Dose

Some schools, colleges, and universities have policies requiring vaccination against meningococcal disease as a condition of enrollment. For ease of program implementation, persons aged 21 years or younger should have documentation of receipt of a dose of meningococcal conjugate vaccine not more than 5 years before enrollment. If the primary dose was administered before the 16th birthday, a booster dose should be administered before enrollment in college. The booster dose can be administered anytime after the 16th birthday to ensure that the booster is provided. The minimum interval between doses of meningococcal conjugate vaccine is 8 weeks.

No data are available on the interchangeability of vaccine products. Whenever feasible, the same brand of vaccine should be used for all doses of the vaccination series. If vaccination providers do not know or have available the type of vaccine product previously administered, any product should be used to continue or complete the series. Persons with complement component deficiency, asplenia, or HIV infection who have previously received a single dose of meningococcal conjugate vaccine should receive their booster dose at the earliest opportunity.

These updated meningococcal conjugate vaccine recommendations from ACIP have been summarized (Table 2). Additionally, a meningococcal conjugate vaccine information statement is available at <http://www.cdc.gov/vaccines/imz/iis/default.htm>, and details regarding the routine meningococcal conjugate vaccination schedule are available at <http://www.cdc.gov/vaccines/imz/iis/updates/default.htm#child>. Adverse events after receipt of any vaccine should be reported to the Vaccine Adverse Event Reporting System at <http://vaers.hhs.gov>.

Last Name

First Name

MI

DOB

Physical Exam

To be completed by physician, physician’s assistant or nurse practitioner. We will accept a copy of your physical examination as long as it is within one year from the time classes begin/student moves on campus.

****STUDENT ATHLETES (including those who are still deciding) are required by the NCAA to have a physical exam within 6 months of beginning collegiate sports. Students should contact Chris Martin, Athletic Trainer at 443-352-4269 if they are unable to fulfill these NCAA requirements.**

Date of Exam: ___/___/___ Age: _____ Sex: Male / Female (please circle) Height: _____ Weight: _____ BP: _____ Pulse: _____

Examination Findings (Describe fully. Use additional sheets if necessary.)

	Normal	Abnormal	Findings (Please describe)
Head, ears, nose or throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/endocrine			
Neuropsychiatric			
Skin			

Diagnosis and Treatment:

Explain history of OR current treatment for any medical or mental health condition

Current medications:

Athletic Clearance: This Section Must Be Completed & Signed By The Attending Practitioner

1: Cleared for Full Activity in ALL Sport Competition: YES _____ NO _____

Explanation for NO: _____

2: Cleared After Completing Evaluation for: _____

3: **NOT CLEARED FOR:** Collision Sports (Football, Lacrosse, Hockey) _____

Contact Sports (Basketball, Baseball, Softball, Volleyball) _____

Non-Contact Sports (Tennis, Cross-Country, Golf) _____

Practitioner’s signature (required) _____ Date: _____

Print/stamp practitioner name: _____ Phone number: _____ Fax number: _____

Address: _____

Street Number

Street Name

City

MD

Zip Code