

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

OFFICE USE ONLY:

Date Entered: _____

Student ID #: _____

Housing Commuter

ALL FULL TIME STUDENTS

This Student Health Form must be completed and returned by Aug. 1st for all Fall entrance or Jan. 2nd for Spring entrance.

GENERAL INFORMATION

Name: _____ Social Security No. (Last Four Digits): _____
Last First Middle

Address: _____
Number and Street City State Zip Code

Home Phone: _____ Cell Phone: _____
Including Area Code Including Area Code

Date of Birth: ____/____/____ Sex: Male Female
Mo. Day Year

Term Entering: Fall ____ Spring ____ Transfer ____
Year Year Year

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name: _____ Relationship: _____

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

CONSENTS

RELEASE OF MEDICAL RECORD INFORMATION
 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
 Student Signature

Date
 Parent/Legal Guardian Signature, if student is under 18 years of age.

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 if needed, and in case of emergency and in the event that I am unavailable, to be taken to the nearest emergency care center to hospital for treatment.

Date
 Signature of Parent/Guardian if student is under 18 years of age.

INSURANCE CARD INFORMATION: Please attach a copy of your insurance card

Last Name

First Name

MI

DOB

MANDATORY FOR STEVENSON UNIVERSITY REGISTRATION.

THE FOLLOWING MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET UNIVERSITY REQUIREMENTS.

PERSONAL MEDICAL HISTORY

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Major surgery (specify type) |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Depression | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hospitalizations (specific cause) | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dizzy/Fainting spells | <input type="checkbox"/> Hypoglycemia (low blood pressure) | <input type="checkbox"/> Strep Throat |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Infectious Mono | <input type="checkbox"/> Sinus problems (chronic) |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Epilepsy/Seizers | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Bronchitis (Chronic) | <input type="checkbox"/> Head injury/concussion | | |

CURRENT ILLNESSES OR CONDITIONS

Illness/Condition: _____ Year Diagnosed: _____
Current Treatment: _____

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)

Physical Exam To be completed by physician, physician's assistant or nurse practitioner no more than twelve months prior to university entrance.

Date of Exam: ___/___/___ Height: _____ Weight: _____ BP: _____
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:

History of OR current treatment for any medical or mental health condition

Explain:

Current medications:

Last Name

First Name

MI

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TUBERCULOSIS RISK ASSESSMENT

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for the patient. 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	<input type="checkbox"/>

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

First Name

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IMMUNIZATION RECORDS

Meningococcal Vaccine Requirement *For students residing on campus

(Health-General Article 18-102(b) Annotated Code of Maryland 10.06.05 Meningococcal Vaccination Requirements for Students in Institutions of Higher Education)

Date Received: ___/___/___
Mo. Day Yr.

Menactra (MCV4) Vaccine

Menomune (MPSV4) Vaccine

Varicella – Check one of the following:

Dose 1: ___/___/___ Dose 2: ___/___/___
Mo. Day Yr. Mo. Day Yr.

History of Disease ___/___/___
Mo. Day Yr.

Varicella Titer (copy of lab results must be attached) ___/___/___ Immune (please circle): Yes/No
Mo. Day Yr.

Measles, Mumps, Rubella (MMR) – Check one of the following:

Dose 1: (12 months after birth or later) ___/___/___ Dose 2: (Any time 1 month after dose #1) ___/___/___
Mo. Day Yr. Mo. Day Yr.

MMR Titer (copy of lab results must be attached) ___/___/___ Immune (please circle): Yes/No
Mo. Day Yr.

Born before 1957 and considered immune

Practitioner's signature (required) _____ **Date:** _____

Print or stamp name _____ **Fax number:** _____

Address: _____
Street Number Street Name City MD Zip Code

To be completed by student:

Before turning in your Student Health Form check to see the following is completed with the necessary attachments:

- General Information
- Person to notify in case of emergency
- Consents
- Copy of insurance card attached
- Personal medical history
- Physical Exam (within 12 months prior to university entrance)
- Tuberculosis Risk Assessment / Test (only if sections 1-4 are checked)
- Meningococcal Vaccine (if living on campus)
- Measles, Mumps, Rubella (MMR) (doses, titer or born before 1957)
- Varicella (doses, history or titer)

X _____ Date: _____
Print Name / Signature