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UNIVERSITY
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100 Campus Circle
Owings Mills, Maryland 21117-7803

www.stevenson.edu

Academic Year 2009- 2010

Dear Student,

On behalf of Stevenson University, I welcome you and wish you four years of good health and much success. I would like to take this opportunity to inform you of the student health requirements. Stevenson University follows the guidelines set by the Centers for Disease Control (CDC) and the State of Maryland for immunization requirements and recommendations.

All full-time students are required to have the Stevenson University Student Health Form completed and returned by August 1, 2009 for fall entrance and January 1, 2010 for spring entrance. Parts I, II, III, IV and the Tuberculosis Risk Assessment Form must be completed by you, prior to your appointment with your health care provider. Part V of the Student Health Form must be completed and signed, and dates properly entered by your health care provider at the time of your physical exam.

All students residing in the Stevenson University student housing are required to be immunized against Meningococcal disease with the vaccine Menactra (MCV4) **or** Menomune (MPSV4). Meningococcal meningitis is a rare but potentially fatal bacterial infection. Certain social behaviors of college students and dormitory living may put students at an increased risk for contracting the disease, along with facilitating the spread of the disease. Freshmen living in dormitories have a six-fold increased risk for meningitis. The available vaccine protects against four out of the five strains of the disease. These four strains cause up to 85% of meningitis cases among college students. Please discuss this important health issue with your health care provider. Exceptions for religious or medical reasons are reviewed by the Associate Dean and the Director of the Wellness Center. You may also further your knowledge about meningitis by visiting the American College Health Association website (www.acha.org) and the CDC website (www.cdc.gov). The cost of the vaccine is about $125.00 (covered by major medical insurances) which is inexpensive, relative to the devastating effect of the illness. Other students not living in campus housing may also wish to reduce their risk of meningococcal meningitis and choose to be vaccinated.

Housing students **will not be permitted to move in** unless the Student Health Form is complete and on file with the Wellness Center by the above deadline.

For those students interested in participating in **varsity athletics**, additional **"Physical paperwork" forms** are required by the Athletic Department. Please contact the head coach associated with the sport about completing this requirement. The **Student Health Form and the Athletic physical paperwork forms must be completed before any try-outs or practices.**

Be sure to have your health care provider review the Student Health form carefully and update immunizations as necessary to fulfill our requirements. **Failure to complete these forms by the deadline may result in delaying your start of classes.** Therefore, I recommend that you make an appointment with your health care provider upon receiving this letter. If you have any questions, please feel free to contact me or our Administrative Assistant, Suzanne Hutter at 443-352-4200.

Sincerely,

Pamela A. Kelleman, BSN, RN
Assistant Director, Wellness Center

Phone 443.352.4200 FAX 443.352.4201

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

Tuberculosis Risk Assessment Form

....

Student Name ______________________ Social Security Number (Last four digits) ______________________

The Centers for Disease Control and Prevention and the United State Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

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 you. **IF YOU CHECK ANY OF THE BOXES IN SECTIONS 1-5 YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST. A HISTORY OF BCG VACCINATION SHOULD NOT PRECLUDE TESTING OF A MEMBER OF A HIGH-RISK GROUP.** Check the box at the bottom of the page if sections 1-5 do not apply to you. Sign and date the form at the bottom. If you are under eighteen years of age, your parent or guardian will need to sign the form.

☐ **Section 1:** Check this box if you have 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 you have 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 jejuno-ileal bypass
- Greater than 10% below ideal body weight

☐ **Section 4:** Check this box if you are a **Nursing or Medical Technology major.**

☐ **Section 5:** 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 Prevalence of Tuberculosis** as defined by the World Health Organization and the state health department:

- **Africa**—All countries
- **Asia/Southeast Asia/Pacific Islands**—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, Venezuala
- **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, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

☐ **No, none of the items listed in sections 1-5 apply to me.**

______________________ ______________________

Student Signature (Parent Signature if student is under 18 years of age) Date

Updated: Feb. 2009

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Owings Mills, MD. 21117-2857
443-352-4200 Fax: 443-352-4201

Office Use Only

Date entered:______________________

Student ID#:______________________

Housing: ☐ Commuter: ☐

Major Study:______________________

This **Student Health Form** must be completed and returned by **Aug. 1** for fall entrance or **Jan. 2** for spring entrance.

PART I.

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

Address:______________________ Home Phone: ______________ Cell Phone:______________
Number and Street With Area Code With Area Code

______________________ Date of Birth: ________ /________ /________
City State Zip Code Month Day Year

Term Entering: ☐ Fall______ ☐ Spring______ ☐ Freshman ☐ Transfer Sex: ☐ Male ☐ Female
year year

PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name:______________________ Home Phone:______________________

Relationship:______________________ Work Phone:______________ Cell Phone:______________

PRIMARY PHYSICIAN / HEALTH INSURANCE:

Physician/Provider:______________________ Telephone No.:______________ Fax No.:______________

Address:____

Health Insurance:____

Policy Holder's Name:______________________ Policy No.:______________________

Part IIa: RELEASE OF MEDICAL RECORD INFORMATION (part a):
I hereby authorize AND CONSENT FOR ANY Health Care Provider who has rendered medical services to the student to disclose medical record information contained on this form to Stevenson University.

______________________ ______________________
Student Signature DATE: **Parent/Legal Guardian Signature, if student is under 18 years of age** DATE:

AND PART IIb: RELEASE OF MEDICAL RECORD INFORMATION (part b):
I hereby authorize Stevenson University to disclose information on the health forms to any Health Care Provider who has rendered medical services to me.

______________________ ______________________
Student Signature DATE: **Parent/Legal Guardian Signature, if student is under 18 years of age** DATE:

PART IIIa: CONSENT FOR MEDICAL TREATMENT:
I hereby authorize Stevenson University, in case of emergency and in the event that I am unable to give my consent, to have me taken to the nearest emergency care center or hospital for treatment.

____
Student Signature Date

OR PART IIIb: 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 or hospital for treatment.

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

Last Name ____ First Name ____ MI ____ DOB ____

PART IV: PERSONAL MEDICAL HISTORY: Check to indicate history or current illness of any of the following.

- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Anxiety Disorder
- ☐ Asthma
- ☐ Back problems
- ☐ Bleeding disorder
- ☐ Bronchitis (chronic)
- ☐ Cancer
- ☐ Celiac disease
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy/Fainting spells
- ☐ Ear infection
- ☐ Epilepsy/Seizures
- ☐ Head injury/concussion
- ☐ Hearing problem
- ☐ Heart problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hospitalizations (specific cause)
- ☐ Hypoglycemia (low blood sugar)
- ☐ Infectious Mono
- ☐ Irritable bowel syndrome
- ☐ Kidney infections/Stones
- ☐ Leukemia/Lymphoma
- ☐ Major surgery (specify type)
- ☐ Migraine
- ☐ Peptic ulcer disease
- ☐ Pneumonia
- ☐ Strep Throat
- ☐ Sinus problems (chronic)
- ☐ Thyroid Disorder
- ☐ Vision problems
- ☐ Other:____

☐ **Denies any of the above medical illnesses or conditions.**

CURRENT ILLNESSES OR CONDITIONS:

Illness/Condition:____ Year diagnosed:____

Current treatment:____

MEDICATIONS: List all medications taken on a regular or frequent basis. Include birth control pills and nonprescription drugs.

Drug	Dose	Drug	Dose
____	____	____	____
____	____	____	____

ALLERGIES: ☐ NONE

☐ Drug allergies (specify)____

☐ Other allergies (specify)____

Do you carry an Epi-Pen? ☐ Yes ☐ No

MANDATORY IMMUNIZATIONS FOR STEVENSON UNIVERSITY REGISTRATION.

ALL DOCUMENTATION OF THE PART V IMMUNIZATION RECORD MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET UNIVERSITY REQUIREMENTS.

PART V: IMMUNIZATION RECORD

____ Student Name ____ Date of Birth

A. Meningococcal Vaccine Requirement

All students residing in the Stevenson University student housing are required to be immunized against Meningococcal disease with the vaccine Menactra (MCV4) OR Menomune (MPSV4).

Meningococcal meningitis is a rare but potentially fatal bacterial infection. Certain social behaviors of college students and dormitory living may put students at an increased risk for contracting the disease, along with facilitating the spread of the disease. Freshmen living in dormitories have a six-fold increased risk for meningitis. The available vaccine protects against four out of the five strains of the disease. These four strains cause up to 85% of meningitis cases among college students.

Other students not living in campus housing may also wish to reduce their risk of meningococcal meningitis and choose to be vaccinated.

Exceptions for religious or medical reasons are reviewed by the Associate Dean and Director of the Wellness Center.

☐ Menactra (MCV4) Vaccine **OR** ☐ Menomune (MPSV4) Vaccine

Date received: ____ / ____ / ____

____
Signature and title of vaccine administrator required

____________________ ____________________ ________

Last Name First Name MI DOB

PART V: IMMUNIZATION RECORD continued

B. **Measles, Mumps, Rubella (MMR) - 2 doses of live vaccine required or proof of immune titer:**

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

OR

2. MMR titer (copy of lab results must be attached)___ /____ /___ (Mo Day Yr) Immune: ______ Yes ______ No

3. Born before 1957 and considered immune:______Yes

C. **Varicella: <u>All students</u> must have either a history of chicken pox <u>OR</u> documentation of <u>two doses</u> of varicella vaccine* <u>OR</u> a proof of positive varicella titer.***

***<u>ALL Nursing majors</u> must submit proof of positive titer regardless of history of disease in childhood. <u>OR</u> documentation of <u>two doses</u> of varicella vaccine, if no history of chicken pox.**

1. Immunization
   a. Dose #1...#1 _____ /_____ /_____ (Mo Day Yr)
   b. Dose #2...#2 _____ /_____ /_____ (Mo Day Yr)

   OR

2. History of Disease: ______ Yes date:_____ /________ (Mo Yr) No______

   OR

3. Varicella titer (**copy of lab results must be attached**) _____ /_____ /_____ (Mo Day Yr) Immune: ______ Yes ______ No

D. **Tetanus-Diphtheria (Td <u>or</u> Tdap):**

Tetanus-Diphtheria booster must be given within the last ten years: ☐ Td **<u>OR</u>** ☐ Tdap _____ /_____ /_____ (Mo Day Yr)

E. **Polio (OPV <u>or</u> IPV)**

Completed primary series of polio immunization: ______ Yes ______ No

F. **Tuberculosis Screening:**

THE ATTACHED <u>TUBERCULOSIS RISK ASSESSMENT FORM</u> MUST BE COMPLETED BY THE STUDENT OR PARENT, SIGNED AND RETURNED WITH THIS FORM.

ALL NURSING AND MEDICAL TECHNOLOGY STUDENTS ARE <u>REQUIRED</u> TO HAVE AN <u>ANNUAL</u> <u>PPD</u> REGARDLESS OF RISK ASSESSMENT RESPONSES.

ALSO, A HISTORY OF BCG VACCINATION SHOULD NOT PRECLUDE TESTING OF A MEMBER OF A HIGH-RISK GROUP.

Are any of the boxes checked in Sections 1-5 of the Tuberculosis Risk Assessment Form?

______ No **If no, stop.** ______ Yes **If yes, PPD skin testing is required.**

1. Tuberculin Skin Test (PPD)

   Date Given: _____ /_____ /_____ (Mo Day Yr) Date Read: _____ /_____ /_____ (Mo Day Yr)

   Result: _____ mm (Record actual mm of induration; transverse diameter; if no induration, write “0”)

   Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

2. ***<u>If greater than 10mm induration,</u>*** chest x-ray required.

   Date of chest x-ray: _____ /_____ /_____ (Mo Day Yr) Result: Normal ____ Abnormal ____ (Attach copy of chest x-ray report)

3. Document any treatment you have 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	MI	DOB

G. **Hepatitis B Vaccine: Strongly Recommended for all students***

***Required for Nursing and Medical Technology students, unless signed declination form is submitted.**

1. Immunization: Dose #1: _____ /_____ /_____ (Mo / Day / Yr) Dose #2: _____ /_____ /_____ (Mo / Day / Yr) Dose #3: _____ /_____ /_____ (Mo / Day / Yr)

OR

2. Hepatitis B surface antibody: Date: _____ /_____ /_____ (Mo / Day / Yr) Immune: ______ Yes ______ No*
(copy of lab results must be attached)

*** If non-immune, student should complete a second three-dose vaccine series.**

H. **Quadrivalent Human Papillomavirus Vaccine (HPV)*** ***Recommended***

***Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.**

Immunization (HPV): Dose #1: _____ /_____ /_____ (Mo / Day / Yr) Dose #2: _____ /_____ /_____ (Mo / Day / Yr) Dose #3: _____ /_____ /_____ (Mo / Day / Yr)

I. **Diagnosis and Treatment:**
History of OR current treatment for any medical or mental health condition? ☐ Yes ☐ No

Explain:____

Current medications:____

I. **Physical Exam**

To be completed by physician, physician's assistant or nurse practitioner no more than twelve months prior to university entrance. Students participating in varsity athletics may defer this exam in lieu of sports PE (copy must be attached)

Date of Exam:__________________ Height:__________________ Weight:__________________ BP:__________________

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

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

Is there loss or serious impaired function of any paired organ? ☐ Yes ☐ No

Have you any general comments?____

Recommendations for physical activity (PE, intramural) ☐ Unlimited ☐ Limited

Explain:____

Practitioner's signature (required) ____________________ Date ____________________

Print or stamp name ____________________ Phone Number ____________________ Fax Number ____________________

Address ____________________ City ____________________ State ____________ Zip ____________

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Health Care Provider:

Stevenson University follows the guidelines set by the Centers for Disease Control and the State of Maryland for immunization requirements and recommendations. Proof of the following immunizations is required prior to the beginning of classes. Please update immunizations as necessary to meet our college requirements.

Meningococcal Vaccine . . . . . .**All students residing** in Stevenson University student housing **are required** to be immunized against Meningococcal disease **with the vaccine Menactra (MCV4) OR Menomune (MPSV4)**
Other students wishing to reduce their risk of meningitis can also choose to be vaccinated.

Measles, Mumps, Rubella... . . .Two doses of MMR at least 28 days apart after 12 months of age or written documentation of positive immune titer.

Varicella . . . . .Disease diagnosed by physician or **two doses** of varicella vaccine **required** or written documentation of positive immune titer.
***All Nursing majors must submit proof of positive titer regardless of positive disease in childhood OR Two doses of Varicella vaccine is acceptable, if no history of Chicken pox.**

Tetanus-Diphtheria . . . . .Primary series completed. Tetanus booster within past 10 years. Preferably Tdap.

Polio . . . . .Primary series completed, including booster.

Tuberculosis Screening . . . .**All students** must complete the **Tuberculosis Risk Assessment Form**. If a check mark is placed in any of the boxes, the student is required to have a tuberculosis (PPD) screening test.
***Proof required annually for all Nursing and Medical Technology majors.**

Hepatitis B . . . .**Strongly recommended** for all students. ***Required** for **Nursing and Medical Technology majors,** unless signed declination form is submitted.

Quadrivalent Human
Papillomavirus Vaccine (HPV)...Recommended for female college students 11-26 years of age.

If you have any questions, please contact me at 443-352-4200.

Sincerely,

Pamela A. Kelleman, BSN, RN
Assistant Director, Wellness Center

Phone 443.352.4200 FAX 443.352.4201