



HEALTH SERVICES

PLEASE RETURN THIS FORM TO HEALTH SERVICES NO LATER THAN JULY 1.

One Old Ferry Road • Bristol, Rhode Island 02809-2921 • Tel. (401) 254-3156 • Fax (401) 254-3305

TO ALL STUDENTS, PARENTS, HEALTH CARE PROVIDERS: **This completed health form must be returned to Health Services by July 1 (Please mail or fax one copy only).** Please be candid on this form. This is a highly confidential document for the sole use of the professional staff at Health Services. No information on this form will be released without the student's written consent. **Remember** to fill out the *entire* form to avoid any unnecessary delay when you arrive on campus to check-in. The state required immunizations are of particular importance.

PERSONAL INFORMATION (Please Print)

Full Name: _____ Social Security #: _____
Last First Middle

Preferred Name: _____ Email Address _____

Birth Date: _____ Sex: _____ Entrance Year: _____ Class: (Circle One) FR SO JR SR

Place of Birth: _____ How long have you lived in the USA: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Student Cell Phone: _____

PERSON TO BE NOTIFIED IN AN EMERGENCY

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION

Please attach a copy of the front & back of health insurance plan card, prescription plan card, and dental plan card.

Insurance Company Name: _____ Policy #: _____

Claims Address: _____

Subscriber Name: _____

Is pre-authorization required? YES NO Phone Number for Pre-authorization: _____

Prescription Plan Name and Number: _____

Phone Number for Prescription Authorization: _____

IMPORTANT

I grant permission for competent medical authorities to hospitalize and/or provide urgent medical, psychiatric and surgical procedures for the above minor student. Efforts will be made to contact legal guardian.

Parent Signature (if student is under 18): _____ Date: _____

PLEASE PROVIDE YOUR SON / DAUGHTER WITH A CARD FOR YOUR HEALTH INSURANCE, PRESCRIPTION PLAN, AND DENTAL PLAN.

CONFIDENTIAL MEDICAL HISTORY

To Be Completed By Student/Reviewed by Provider

Name: _____ Date of Birth: _____

PLEASE CIRCLE ○ ANY OF THE FOLLOWING CONDITIONS YOU HAVE HAD; EXPLAIN AND GIVE DATES AS NEEDED.

- Acne / Eczema / allergic skin disease
- Asthma / Bronchitis / Pneumonia / Tuberculosis
- Ear Infections /Tonsillitis /Sinusitis / Seasonal allergies
- Mononucleosis / Liver or spleen injury
- Heart murmur / Heart condition
- High blood pressure / Low blood pressure / Phlebitis (blood clot)
- Appendectomy / Hernia
- Diarrhea (chronic) / Blood in the stool / Parasitic infection
- Hepatitis; Type: A B C / Ulcer / Ulcerative colitis / Crohn's disease
- Cystitis (bladder infection) / Blood/Protein in urine
- Nephritis (kidney infection) / Loss of kidney
- Amenorrhea (missed periods) / Dysmenorrhea (painful periods)
- Fractured bones / Severe sprains / ligament injuries / Back pain / Joint pain
- Diabetes / Thyroid disease / Anemia / Sickle cell disease or trait
- Seizures / Severe headaches / Dizzy or fainting spells / Concussion /
- Depression / Anxiety / BiPolar / ADD / Eating disorders / Counseling: yes / no
- Head injury / Loss of consciousness / Eye injury / Eye loss

Have you had Chicken Pox? NO YES Date of disease: _____

If none of the above apply, please check (✓) here _____

Additional comments or problems (Please list any surgery or hospitalizations) _____

Have you had Baseline Impact testing for concussion management? NO YES

Where _____ When _____ Please attach copy of test results if available.

Any ethnic/religious/gender considerations we should know about? NO YES

CURRENT MEDICATIONS: (including vitamins and birth control pills*) _____

ALLERGIES: (food, insect, medication) _____

SECTION B

Have you experienced any of the following during or immediately after exercising?

- | | | | | | |
|------------|--|-----------------|--|-----------------------|--|
| Fainting | <input type="checkbox"/> YES <input type="checkbox"/> NO | Unusual Fatigue | <input type="checkbox"/> YES <input type="checkbox"/> NO | Dizzy or light headed | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Chest Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO | Heart Racing | <input type="checkbox"/> YES <input type="checkbox"/> NO | Shortness of breath | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Hives | <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |

Has any blood relative had any of the following conditions: (including parents, siblings, grandparents, aunts, uncles. Explain below.)

- Early death (Give age and reason) _____
- Heart attack/surgery (Give age) _____
- Cardiomyopathy (Abnormal heart structure) _____
- Marfan's Syndrome _____
- Prolonged QT interval or arrhythmia _____

HEALTH BEHAVIORS

	NO	YES
a. Do you smoke? # cigs/day		
b. Do you chew tobacco?		
c. Have you ever worried about your alcohol use?		
d. Have you ever worried about your drug use?		
e. Do you worry too much about your weight?		
f. Do you have any unhealthy weight control issues		
g. Do you exercise?		
h. If sexually active do you use condoms?		
i. (Men) Do you examine your testicles monthly?		

BIOLOGICAL FAMILY HISTORY

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				
Children				

REQUIRED IMMUNIZATION RECORD

Name: _____ Date of Birth: _____

Social Security #: _____

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED OF ALL STUDENTS

- DPT/DT/TDAP Booster within last 10 years
- MMR Two doses of MMR (Measles, Mumps, Rubella) both given after 12 months of age, or disease confirmed by office record or positive titre
- VARICELLA (chicken pox) One dose after 1 year of age, or two doses after 13 years of age, or disease confirmed by office record or positive titre
- HEPATITIS B Three doses Hepatitis B vaccine required, or positive titre (or two adult doses between the ages of 11-15)

THE FOLLOWING VACCINES ARE REQUIRED. PLEASE PROVIDE DATES OF IMMUNIZATIONS OR POSITIVE TITRE

IMMUNIZATION						
Tetanus Booster	Date of Td booster within 10 years ____/____/____	OR	Tdap booster within 10 years ____/____/____			
MMR <small>*2 doses required</small>	____/____/____	____/____/____		MMR Titre Date and Results ____/____/____	Titre Results	
Hepatitis B	____/____/____	____/____/____	____/____/____	Hepatitis B Titre Date and Results ____/____/____	Titre Results	
Varicella	____/____/____	____/____/____	Date of Disease ____/____/____	Varicella Titre Date and Results ____/____/____	Titre Results	

THE FOLLOWING VACCINES ARE STRONGLY RECOMMENDED BUT NOT REQUIRED.

Meningococcal (Meningitis vaccine)	____/____/____	____/____/____
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HPV Vaccine	____/____/____	____/____/____	____/____/____
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TUBERCULIN SKIN TEST - PPD (Mantoux) required within the past year if high risk.
Risk Assessment: Must complete tuberculosis questionnaire insert to determine risk.

LOW RISK. PPD not required.

HIGH RISK. PPD required regardless of prior BCG inoculations. Complete section below.

PPD (MANTOUX)

Date Given	Date Read	Results		Chest X-ray (if PPD is positive)
____/____/____	____/____/____			Date:
____/____/____	____/____/____			Results:
____/____/____	____/____/____			Treatment:

HEALTH PROVIDER INFORMATION:

Name (print): _____ Phone Number: _____

Address: _____

Signature of Health Provider: _____ Date: _____

Patient Name: _____

DOB: _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Please answer the following questions:

Have you ever had a **positive** TB skin test? YES NO

Have you ever had close contact with anyone who was sick with TB? YES NO

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * (If yes, please CIRCLE the country) YES NO

Have you lived or had extensive travel outside the USA within the past five years to countries with high prevalence of TB? YES NO

Have you ever traveled** to/in one or more of the countries listed below? (If yes, please circle the country/ies) YES NO

Year _____ Duration of stay _____

Reason for travel: vacation / work / residence

**future CDC updates may eliminate the 5 year time frame*

*** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan	Chad	Guinea-Bissau	Mali	Peru	Tanzania-UR
Algeria	China	Guyana	Marshall Islands	Philippines	Thailand
Angola	Colombia	Haiti	Mauritania	Poland	Timor-Leste
Anguilla	Comoros	Honduras	Mauritius	Portugal	Togo
Argentina	Congo	India	Mexico	Qatar	Tokelau
Armenia	Congo DR	Indonesia	Micronesia	Romania	Tonga
Azerbaijan	Cote d'Ivoire	Iran	Moldova-Rep.	Russian Federation	Tunisia
Bahamas	Croatia	Iraq	Mongolia	Rwanda	Turkey
Bahrain	Djibouti	Japan	Montenegro	St. Vincent &	Turkmenistan
Bangladesh	Dominican Republic	Kazakhstan	Morocco	The Grenadines	Tuvalu
Belarus	Ecuador	Kenya	Mozambique	Sao Tome & Principe	Uganda
Belize	Egypt	Kiribati	Myanmar	Saudi Arabia	Ukraine
Benin	El Salvador	Korea-DPR	Namibia	Senegal	Uruguay
Bhutan	Equatorial Guinea	Korea-Republic	Nauru	Seychelles	Uzbekistan
Bolivia	Eritrea	Kuwait	Nepal	Sierra Leone	Vanuatu
Bosnia & Herzegovina	Estonia	Kyrgyzstan	New Caledonia	Singapore	Venezuela
Botswana	Ethiopia	Lao PDR	Nicaragua	Solomon Islands	Viet Nam
Brazil	Fiji	Latvia	Niger	Somalia	Wallis & Futuna Islands
Brunei Darussalam	French Polynesia	Lesotho	Nigeria	South Africa	W. Bank & Gaza Strip
Bulgaria	Gabon	Liberia	Niue	Spain	Yemen
Burkina Faso	Gambia	Lithuania	N. Mariana Islands	Sri Lanka	Zambia
Burundi	Georgia	Macedonia-TFYR	Pakistan	Sudan	Zimbabwe
Cambodia	Ghana	Madagascar	Palau	Suriname	
Cameroon	Guam	Malawi	Panama	Syrian Arab Republic	
Cape Verde	Guatemala	Malaysia	Papua New Guinea	Swaziland	
Central African Rep.	Guinea	Maldives	Paraguay	Tajikistan	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

If you have had a "positive" skin test for Tuberculosis in the past, inform your health care provider. You will not need another test but you may need a chest x-ray.

Health Care Provider please note:

Low Risk is answering "NO" to all above questions.

High Risk is answering "YES" to ONE or more of the above answers.

TRANSFER STUDENTS ONLY

HEALTH RECORD INFORMATION

Transfer students are required to meet both University and State regulations concerning health information.

IF YOU HAVE A HEALTH RECORD ON FILE AT ANOTHER COLLEGE, PLEASE FILL OUT THIS FORM AND SEND IT TO THAT COLLEGE SO THEY MAY FORWARD YOUR RECORDS TO US.

The following information listed below is a requirement.



- Physical - Current within the year
- Immunization Records

TRANSFER STUDENT HEALTH RECORD RELEASE FORM

I hereby authorize _____ to forward my medical history and/or immunization record to:
(Last college attended & dates attended)

Roger Williams University
Attn: Health Services
One Old Ferry Road
Bristol, Rhode Island 02809

Fax 401-254-3305

(Date) (Student Signature) (Print Name)

(D.O.B.) (Social Security#) (Current Address)

TO PREVIOUS COLLEGE ATTENDED:

If you have NO health record for the above listed individual, please just check here and return this form to: Roger Williams University, Attn: Health Services, One Old Ferry Road, Bristol, RI 02809