

# Roger Williams University

## Health Services

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Tel. (401) 254-3156

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**FORMS MUST BE SUBMITTED BY JULY 1 FOR FALL SEMESTER AND JANUARY 1 FOR SPRING SEMESTER**

Dear Incoming Student,

Health Services would like to welcome you to Roger Williams University. We are committed to serving our student's health care needs and partnering with students in promoting their physical and psychological well-being. We collaborate with the larger college community, supporting students in achieving their academic and personal potential. Please visit our website to see the range of services we provide. A list of first aid supplies that students are strongly encouraged to bring to college is provided.

Before you arrive on campus, there are required documents that must be submitted. Rhode Island State Law requires all incoming students to submit health forms and proof of immunization prior to your arrival on campus. **Please return completed health forms to Health Services on or before July 1<sup>st</sup> for fall semester and January 1<sup>st</sup> for spring semester.** If completed health forms and immunization record are not received by the end of the first week of classes, a hold will be placed on your registration which will impact your ability to add/drop courses, register for next semester, and view/receive your grades. Students are responsible for complying with this deadline.

**The following forms must be completed and submitted via mail, fax, or in person:**

- ☐ **Emergency Contact and Consent for Medical Treatment**
- ☐ **Health Insurance Information along with a photocopy of the front and back of insurance card**
- ☐ **Medical History**
- ☐ **Physical Examination** (must be within one year of University entry – six months for athletes)
- ☐ **Immunization Record**
- ☐ **Tuberculosis Risk Screening Questionnaire**

Your health information is confidential and protected by State and Federal Laws. HIPPA regulations prevent us from releasing or discussing any health information without written consent of the patient, except when there is imminent danger to a student or to others, or when required by law.

We are pleased that you have selected Roger Williams University and we look forward to meeting you. If you have any questions or concerns please contact Health Service (401)254-3156.

Kind regards,

*Anne Mitchell*

Anne Mitchell, MSN, FNP

Director of Health Services

# Emergency Contact and Consent for Medical Treatment

## STUDENT INFORMATION: (Please Print)

Full Name: \_\_\_\_\_ Student ID #: \_\_\_\_\_  
Last First Middle

Preferred Pronouns: \_\_\_\_\_ Biological Gender: \_\_\_\_\_ Gender Identity: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ 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: \_\_\_\_\_

Student Email: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION:

Name: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Parent Email: \_\_\_\_\_

### ATHLETES

In addition to completing Health Service health forms, there are separate forms to complete for participation on an athletic team. Please complete both sets of forms and send to the respective departments. Athletic forms can be found at [RWUhawks.com](http://RWUhawks.com) under the Sports Medicine tab or email Joshua King, Head Athletic Trainer, at [jnking@rwu.edu](mailto:jnking@rwu.edu).

## CONSENT FOR MEDICAL CARE:

Student name: \_\_\_\_\_

I grant permission to the Health Services Staff at Roger Williams University to provide medical evaluation and treatment for illness, injury, or immunization administration to the above named student. This includes emergency treatment (including transport, surgery and anesthesia) in the event of a serious illness or injury when a parent or guardian cannot be reached.

Student Signature (REQUIRED): \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(REQUIRED if student is under 18 years of age)

# IMPORTANT INFORMATION ABOUT HEALTH SERVICES & HEALTH INSURANCE

PLEASE READ AND SIGN BELOW.

**Use of Health Services** is covered by the undergraduate student fees. All full-time undergraduate day students have access to Health Services. There is no charge for visits to Health Services for illness or injury.

Charges will be incurred for routine well physical exams, immunizations, lab work, prescription medication and referrals to outside providers. These charges can be submitted to your health insurance. Charges not covered by your health insurance will be billed directly to the student by the provider of the service.

**Students should have a copy of their insurance card in their possession** and provide Health Services with a copy of the front and back of the card. We encourage students to carry their card with them or have a picture of it on their cell phone should they need to access medical care at an urgent care, ER, pharmacy, lab or outside provider. Be aware of deductibles and prior approvals needed for procedures or referrals. If insurance information is not available at the time of service, the bill will be sent to the student directly.

## HEALTH INSURANCE: ALL STUDENTS ARE REQUIRED TO SHOW PROOF OF HEALTH INSURANCE

**All full-time undergraduate students, residential and commuter, international students and Masters of Architecture students are automatically enrolled** in the Student Health Insurance Plan. If you have a comprehensive insurance plan, you can opt to waive the Student Health Insurance. You must go to <http://www.rwu.edu/go/insurance> and follow the instructions to waive. This must be done no later than August 14. **If you do not complete the on-line waiver process by August 14, you are automatically enrolled in the Student Health Insurance and a charge will appear on your e-bill.**

## IMPORTANT CONSIDERATIONS WHEN DECIDING ON A HEALTH INSURANCE PLAN:

1. Does it pay out of network? Some plans (HMO's or state plans) are best utilized if care is obtained by a network provider. Limited coverage, possibly only emergency coverage, is provided out of network. If you currently have a limited network plan you may choose to have your student enroll in the Student Health Insurance Plan which is a PPO plan, well accepted in RI.
2. Does your current policy have a high deductible? It has become more common for policies to have deductibles of \$2,000 - \$5,000. This means you pay out of pocket until you have reached your deductible. In this case enrolling in the student Health Plan can cover the deductible gap.
3. Regardless of your health plan the student must have a copy of the card in his/her possession in order for health charges to be applied; otherwise the student will be billed directly.

I have read the above and understand that any charges incurred that are not covered by my Health Insurance are my responsibility. An insurance card must be presented to the rendering provider for a claim to be submitted, therefore all students should carry a copy of their insurance card on them.

**Student Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# MEDICAL HISTORY

## To Be Completed By Student

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PLEASE CIRCLE ☐ ALL THAT APPLY AND INCLUDE DATES AS NEEDED:

<b>Cancer:</b> _____	Mononucleosis Seasonal Allergies Sinusitis Tonsillitis Tonsillectomy & Adenoidectomy	Bone Fracture Ligament Injuries Severe sprains	<b>Respiratory:</b> Asthma: NO YES (circle one) Well controlled? NO YES (circle one) Pneumonia Tuberculosis Anaphylaxis (severe allergic reaction)
<b>Cardiovascular:</b> Anemia Blood Clotting Disorder Congenital Heart Defects Dizzy or fainting spells Heart Condition/Murmur High/Low Blood Pressure Phlebitis (Blood Clot) Sickle Cell Disease/Trait	<b>GI/Abdominal:</b> Appendectomy Blood in stool Crohn's Disease Diarrhea (chronic) Hepatitis A/B/C Hernia IBS Liver/splenic injury Parasitic Infection Ulcer / GERD Ulcerative Colitis	<b>Neurological:</b> Concussion Head Injury Migraines/severe headaches Seizure disorder	<b>Skin:</b> Acne Eczema Hives Psoriasis
<b>Endocrine:</b> Diabetes (Type 1 or 2) Thyroid disease	<b>Musculoskeletal:</b> Back Pain	<b>Psychological:</b> Counseling: NO YES (circle one) <b>If YES provide dates:</b> _____ ADD/ADHD Anxiety Autism Spectrum Disorder Bipolar Depression Eating Disorder	<b>Urology:</b> Blood/Protein in Urine Kidney Stones Loss of Kidney Nephritis (Kidney Infection) Urinary Tract Infection
<b>EENT (eye, ear, nose, throat):</b> Ear Infections Eye Injury/Vision Loss			

Other illnesses/surgeries or hospitalizations (include dates): \_\_\_\_\_

Have you had Chicken Pox NO YES (circle one) Date of Disease required: \_\_\_\_\_

**ALLERGIES:** (food, insect, medication)/specify reaction: \_\_\_\_\_

Do the allergies listed above require the use of an Epi Pen? NO YES (circle one)

**CURRENT MEDICATIONS:** (including birth control pills & vitamins) \_\_\_\_\_

Any cultural/religious/gender considerations we should be aware of? NO YES (circle one) Explain \_\_\_\_\_

HEALTH BEHAVIORS	No	Yes
a. Do you Smoke/Vape/use eCigarettes?		
b. Do you chew tobacco?		
c. Do you drink alcohol? If yes, how much/how often do you drink? _____		
d. Do you use recreational drugs? If yes, what drug: _____		
d. Do you worry too much about your weight or have any unhealthy weight control issues?		
e. Do you exercise regularly? (150 minutes a week is recommended)		
f. Do you eat a well-balanced diet? (this should include at least 5-7 fruits and vegetables per day)		
g. Are you sexually active?		
h. If sexually active, do you use condoms?		

## BIOLOGICAL FAMILY HISTORY

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

## PHYSICAL EXAMINATION

To Be Completed by Health Care Provider within one (1) year prior to college start date

Student Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_  
Last First Middle

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ Visual Acuity: (R) \_\_\_\_\_ (L) \_\_\_\_\_  
(corrected/uncorrected)

Has the patient experienced any of the following during or immediately after exercising?

Fainting ☐ YES ☐ NO Unusual Fatigue ☐ YES ☐ NO Dizzy or light headed ☐ YES ☐ NO  
Chest Pain ☐ YES ☐ NO Heart Racing ☐ YES ☐ NO Shortness of breath ☐ YES ☐ NO  
Hives ☐ YES ☐ 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 \_\_\_\_\_

SYSTEM	NORMAL	ABNORMAL	EXPLAIN ABNORMAL FINDINGS
1. Skin			
2. Ears			
3. Eyes			
4. Nose, throat, teeth			
5. Neck, thyroid			
6. Chest, breasts			
7. Lungs			
8. Heart			
9. Abdomen, kidneys			
10. Genitalia			
11. Pelvic (if indicated)			
12. Rectal (if indicated)			
13. Lymphatic			
14. Extremities, back, spine			
15. Neurological			
16. Psychological			

**\*If the student is under your care for a chronic condition, please provide us with a care plan to assist us in providing continuity of care.**

### SPORTS CLEARANCE:

Based on review of Medical H/P is this student able to participate in sports without restriction? (circle one) YES NO

### ALLERGY HISTORY

Does this student have any allergies (food, insect, medication)? (circle one) YES NO

Please list allergies \_\_\_\_\_

Do the allergies listed above require the use of epinephrine? (circle one) YES NO

If yes, has an epi-pen and instruction for use been provided to the student? (circle one) YES NO

I have reviewed this student's medical history:

Provider Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# IMMUNIZATION RECORD

## To Be Completed By Health Care Provider

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Student ID #: \_\_\_\_\_

### THE FOLLOWING IMMUNIZATIONS ARE REQUIRED BY RI DEPARTMENT OF HEALTH FOR ALL STUDENTS

DPT/DT/TDAP	Must have one (1) Tdap & also last dose of Td or Tdap must be 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)
MENINGITIS VACCINE	One dose of meningococcal conjugate (MCV4) vaccine is required for students previously unvaccinated (under 22 years of age). A second booster dose is required if the first dose was given before 16 years of age.

### THE FOLLOWING VACCINES ARE REQUIRED INCLUDING DATES (MM/DD/YY) OF IMMUNIZATIONS OR POSITIVE TITRE.

IMMUNIZATION						
DPT/TD	Dose #1 ____/____/____	Dose #2 ____/____/____	Dose #3 ____/____/____	Dose #4 ____/____/____	Date of Td booster within 10 years ____/____/____	<b>OR</b> Tdap booster within 10 years ____/____/____
MMR *2 doses required	Dose #1 ____/____/____	Dose #2 ____/____/____		Titre Date ____/____/____	Titre Result	
Measles			Date of Disease ____/____/____	Titre Date ____/____/____	Titre Result	
Mumps			Date of Disease ____/____/____	Titre Date ____/____/____	Titre Result	
Rubella			Date of Disease ____/____/____	Titre Date ____/____/____	Titre Result	
Hepatitis B	Dose #1 ____/____/____	Dose #2 ____/____/____	Dose #3 ____/____/____	Titre Date ____/____/____	Titre Result	
Varicella	Dose #1 ____/____/____	Dose #2 ____/____/____	Date of Disease ____/____/____	Titre Date ____/____/____	Titre Result	
Meningococcal Vaccine (MCV <sub>4</sub> )	Dose #1 ____/____/____	Dose #2 ____/____/____				

### THE FOLLOWING VACCINES ARE RECOMMENDED BUT NOT REQUIRED.

HPV Vaccine	Dose #1 ____/____/____	Dose #2 ____/____/____	Dose #3 ____/____/____
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Meningitis B Vaccine	Dose #1 ____/____/____	Dose #2 ____/____/____
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**TUBERCULIN SKIN TEST** - PPD required within the past year if high risk.  
Tuberculosis Risk Screening Questionnaire must be completed to determine risk.

**IGRA/QUANTIFERON RESULT** \_\_\_\_\_  
Date

\_\_\_\_ **LOW RISK.** PPD not required.      \_\_\_\_ **HIGH RISK.** PPD required.      \_\_\_\_ **BCG VACCINE:** \_\_\_\_\_  
Date

#### 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: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

# TUBERCULOSIS (TB) RISK SCREENING QUESTIONNAIRE

## (TO BE COMPLETED BY ALL INCOMING STUDENTS)

### Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease? YES NO
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? YES NO
- If yes, please CIRCLE the country below.**
3. Have you traveled to any of the countries or territories listed below that have a high prevalence of TB disease? YES NO  
**If yes: CIRCLE the countries or territories below AND provide dates of travel and length of stay.**  
 Month/Year: \_\_\_\_\_ Length of stay: \_\_\_\_\_
4. Have you been a resident and/or employee of high-risk congregated settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? YES NO
5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? YES NO
6. Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? YES NO

If the answer is YES to any of the above questions, Roger Williams University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

Afghanistan	China	Guam	Malaysia	Paraguay	Tajikistan
Algeria	China, Hong Kong SAR	Guatemala	Maldives	Peru	Thailand
Angola	China, Macao SAR	Guinea	Mali	Philippines	Timor-Leste
Anguilla	Colombia	Guinea-Bissau	Marshall Islands	Poland	Togo
Argentina	Comoros	Guyana	Mauritania	Portugal	Trinidad and Tobago
Armenia	Congo	Haiti	Mauritius	Qatar	Tunisia
Azerbaijan	Côte d'Ivoire	Honduras	Mexico	Republic of Korea	Turkmenistan
Bangladesh	Democratic People's	India	Micronesia	Republic of Moldova	Tuvalu
Belarus	Republic of Korea	Indonesia	(Federated States of)	Romania	Uganda
Belize	Democratic Republic of	Iran	Mongolia	Russian Federation	Ukraine
Benin	the Congo	(Islamic Republic of)	Montenegro	Rwanda	United Republic of
Bhutan	Djibouti	Iraq	Morocco	Saint Vincent and the	Tanzania
Bolivia	Dominican Republic	Kazakhstan	Mozambique	Grenadines	Uruguay
(Plurinational State of)	Ecuador	Kenya	Myanmar	Sao Tome and Principe	Uzbekistan
Bosnia and Herzegovina	El Salvador	Kiribati	Namibia	Senegal	Vanuatu
Botswana	Equatorial Guinea	Kuwait	Nauru	Serbia	Venezuela (Bolivarian
Brazil	Eritrea	Kyrgyzstan	Nepal	Seychelles	Republic of)
Brunei Darussalam	Estonia	Lao People's	Nicaragua	Sierra Leone	Vietnam
Bulgaria	Ethiopia	Democratic Republic	Niger	Singapore	Yemen
Burkina Faso	Fiji	Latvia	Nigeria	Solomon Islands	Zambia
Burundi	French Polynesia	Lesotho	Northern Mariana	Somalia South Africa	Zimbabwe
Cabo Verde	Gabon	Liberia	Islands	South Sudan	
Cambodia	Gambia	Libya	Pakistan	Sri Lanka	
Cameroon	Georgia	Lithuania	Palau	Sudan	
Central African Republic	Ghana	Madagascar	Panama	Suriname	
Chad	Greenland	Malawi	Papua New Guinea	Swaziland	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of  $\geq 20$  cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

## Items Every College Student Should Bring To College

A first aid/health kit is on every “dorm essentials” list so that you have supplies readily available for you to use in the event you are injured or sick. We strongly recommend you bring the following items with you to school.

### **First Aid**

- \* Acetaminophen (Tylenol) – fever/pain
- \* Ibuprofen (Motrin) - fever/pain/inflammation
- \* Instant ice packs/heat packs
- \* Thermometer
- \* Band aids in various sizes
- \* Bacitracin or Neosporin
- \* Hydrocortisone cream
- \* Antifungal cream and powder
- \* Rolled gauze
- \* Sterile gauze pads 2×2 and 4×4
- \* Ace bandages in various sizes
- \* Scissors
- \* Rubbing alcohol 70%
- \* Hydrogen peroxide
- \* Chap Stick
- \* Artificial tears eye lubricant- (Gen Teal, Systane, Refresh) for dry eyes
- \* Sunscreen
- \* Bug repellent
- \* Aloe vera gel
- \* Calamine lotion

**Cough and Colds:** Many of the combination products contain acetaminophen and are mistakenly taken along with more acetaminophen which can lead to liver toxicity and overdose.

- \* Pseudoephedrine or phenylephrine (Sudafed)
- \* Cough syrup/cough drops/throat lozenges
- \* Guaifenesin (Mucinex, Robitussin)
- \* Vick’s vaporub
- \* Nasal Saline Spray

### **Allergies:**

- \* Diphenhydramine (Benadryl, Dramamine) or cetirizine (Zyrtec) or loratadine (Claritin, Alavert)

### **Stomach Ailments:**

- \* Tums or Maalox
- \* Gas-x

Health Services has limited over-the-counter medications available for purchase.