

JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEET

(To be completed by student – we suggest you make a copy of this 3 page form for your records)

_____ Last Name	_____ First name	_____ MI	_____ Date of Birth	_____ Gender	_____ Graduating Class
_____ Street Address					_____ ()
_____ City/Town		_____ State	_____ Zip	_____ Student Cell Phone	
_____ Parent/Guardian			_____ Address		
_____ () Home Phone		_____ () Business Phone		_____ () Cell Phone	
_____ Emergency contact (other than above)		_____ () Home Phone		_____ () Business Phone	

INSURANCE INFORMATION - ****Attach a copy of your insurance card (front and back) for our records.**** The student should also carry his or her own insurance card with them while they are at school.

Subscriber's name _____ Relationship to student _____

***If prior approval is needed for lab work, referrals or hospitalizations, please provide the student with the necessary information so he/she can get approvals. The Health Center is not responsible for obtaining prior authorizations and approvals.*

HEALTH INFORMATION

Chronic health problems (i.e. asthma, diabetes, etc.), disabilities, special needs _____

Current medications _____

Do you have any allergies to medication? Yes _____ No _____ List _____

Do you have any other allergies? Yes _____ No _____ List _____

Have you ever had surgery? If so, when and what? _____

CONSENT FOR MEDICAL CARE – for parents/guardians of applicants under 18 years of age only

I, _____, as parent/guardian of _____
(print your full name) (print student's full name)

do hereby authorize the staff at the Juniata College Health & Wellness Center to provide routine medical care to my child. This may include ordering lab tests, performing physical exams, treatment of minor illnesses and injuries, and administering immunizations. I also authorize the Center staff to seek emergency medical care if necessary.

I understand that this authorization may be revoked, in writing, at any time.

Signed: _____ Date: _____

****Please note:** Your health record will be kept on file at the Health & Wellness Center for seven years after graduation, at which time it will be destroyed.

IMMUNIZATION RECORD

Name: _____ DOB: _____

****To be completed and signed by your health care provider****

REQUIRED IMMUNIZATIONS:

1. MEASLES, MUMPS, RUBELLA: **Required** The earliest the first immunization can be given is 12 months of age.

1st MMR: ____/____/____

2nd MMR: ____/____/____ OR Measles (Rubeola) ____/____/____

OR documented positive titer Measles (Rubeola) ____/____ Mumps ____/____ Rubella ____/____

2. MENINGITIS VACCINE dates: (**Required** to live on campus) ____/____/____; ____/____/____
Booster is **REQUIRED** if first dose given prior to age 16

3. TETANUS, DIPHTHERIA & PERTUSSIS booster: (**Required** within last 10 years) ____/____/____

4. POLIO: (**Required**) Completed primary series of polio immunization? yes ____ no ____
Date of last booster: ____/____/____ Type: OPV ____ IPV ____ EP-IPV ____

HIGHLY RECOMMENDED IMMUNIZATIONS:

5. VARICELLA: history of disease (year) ____ OR vaccine dates: ____/____/____; ____/____/____

6. HEPATITIS B: Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

7. HEPATITIS A: First dose: ____/____/____ Second dose: ____/____/____

8. TB SCREENING ALL students **MUST** fill out the enclosed TB screening questionnaire, and receive a TB test prior to arrival on campus if needed.

TB skin test (PPD) Date ____/____/____ Results _____ (mm induration)

If more than 5 mm, please provide proof of last chest x-ray and treatment if applicable.

HEALTH CARE PROVIDER

Printed Name _____ Signature _____

Address _____ Phone (____) _____

STUDENT RELEASE: I authorize Juniata College to release my immunization record upon my verbal request. I understand release of all other information contained in my medical record will require my written authorization.

Student signature _____ Date _____

PHYSICIAN'S REPORT OF HEALTH EVALUATION

To the examining physician: Please review the student's history and complete the physician's report and immunization record.

STUDENT'S NAME: _____ **DOB:** _____

B/P _____/_____
Pulse _____ reg _____ irr _____ Height _____ Weight _____
Vision R20/____ L20/____ Corrected R20/____ L20/____ Hearing R _____/____ L____/____

Normal Abnormal Explain:

1	HEENT			
2	Respiratory			
3	Cardiovascular			Murmur Y N
4	Skin			
5	Spine			
6	Lymphatics			
7	Thyroid			
8	Abdomen			
9	Extremities			
10	Psychiatric			
11	Neurologic			

General Health – please attach a separate sheet for the following questions if necessary:

Have you any general comments regarding the care of this student? _____

Is the student under treatment for any medical/emotional conditions? _____

Does the student have any significant medical history of which we should be aware? _____

Has the student ever had surgery? If yes, when and what? _____

Please furnish as much information as possible so that we may help you care for your patient while they are on campus. Also please note that the Health Center is closed during the summer and over school breaks.

Gynecological History

Menstruation age of onset: _____; lasts _____ days; regular ☐ every _____ days; irregular ☐

Pain: never ☐ sometimes ☐ always ☐ Usual treatment of pain _____

Date of physical exam: ____/____/____

Physician's Name (printed)

Address

(____) _____

Phone

Physician's signature

City / State / Zip

(____) _____

Fax

Tuberculosis (TB) Screening Questionnaire

Must be completed by ALL students:

Have you had close contact with anyone who was sick with TB? ☐ Yes ☐ No
 Do you have a compromised immune system: ☐ Yes ☐ No
 Were you born in one of the countries listed below, or have you spent significant time in one or more of the countries below? (Circle country) ☐ Yes ☐ No

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

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ☐ Yes ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

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, Juniata College requires that you receive TB testing as soon as possible and BEFORE the start of the semester.

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