JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEEET

(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. GARDASIL: 1st dose: _____/_____/_____; 2nd dose: _____/_____/_____; 3rd dose: _____/_____/_____

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

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) Physician's signature

_____ _____

Address City / State / Zip

(_____) _____ (_____) _____

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

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.

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Student Name: _____ DOB: _____