JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEET

(To be completed by student – we suggest you make a copy of this 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. Health Services 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 Services 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 Health Services for seven years after graduation, at which time it will be destroyed.

Juniata College Health Services
1700 Moore Street
Huntingdon, PA 16652
Phone: (814) 641-3410
Fax: (814)-641-3712

JUNIATA COLLEGE IMMUNIZATION VERIFCATION FORM

LAST NAME	**FIRST NAME**	**DATE OF BIRTH (MM/DD/YYYY)**

REQUIRED VACCINES:

Measles, Mumps, Rubella				
Measles, Mumps, Rubella **REQUIRED** for **ALL** students. Dose 1 MUST be given on or after **1st birthday** Dose 2 must have been given at least **4 weeks** after Dose 1 2 doses of MMR vaccine OR Individual vaccines - 2 doses of Measles, 2 doses of Mumps, 1 dose of Rubella OR Blood test titer results confirming immunity- **(equivocal and negative results are NOT accepted)**	**MMR Dose 1** ___/___/___ MM DD YYYY	**Measles dose 1** ___/___/___ MM DD YYYY	**Mumps Dose 1** ___/___/___ MM DD YYYY	**Rubella Dose 1** ___/___/___ MM DD YYYY
	MMR Dose 2 ___/___/___ MM DD YYYY	**Measles dose 2** ___/___/___ MM DD YYYY	**Mumps dose 2** ___/___/___ MM DD YYYY	
	Measles titer ___/___/___ MM DD YYYY	**Mumps titer** ___/___/___ MM DD YYYY	**Rubella titer** ___/___/___ MM DD YYYY	***Attach a copy of lab results (Required if providing titer information)**

Meningococcal Conjugate (MCV4)			
Meningococcal Conjugate (MCV4) **REQUIRED for students living in College Housing** (If first dose is given prior to age **16** a **booster** is indicated)	**Meningitis MCV4** ___/___/___ MM DD YYYY	**Meningitis MCV4** ___/___/___ MM DD YYYY	**Please specify vaccine type such as Menactra or Menveo :** ______________________

Tdap		
Tdap (tetanus, diphtheria, and pertussis) [this is not the same as DTap] REQUIRED Must be within the last ten years.	**Tdap** ___/___/___ MM DD YYYY	**Please specify vaccine type such as Boostrix or Adacel:** ______________________

Polio (Required) Completed Primary series of immunization? **Yes__No__**

Date of last booster: ___/___/___ Type: **OPV___IPV_____EP-IPV**

MM DD YYYY

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HIGHLY RECOMMENDED IMMUNIZATIONS:

Hepatitis A	**Hep A Dose 1** ___/___/___ MM DD YYYY	**Hep A Dose 2** ___/___/___ MM DD YYYY	
Hepatitis B	**Hep B Dose 1** ___/___/___ MM DD YYYY	**Hep B Dose 2** ___/___/___ MM DD YYYY	**Hep B Dose 3** ___/___/___ MM DD YYYY
HPV **(Human Papilloma)** **Type:**____________	**HPV Dose 1** ___/___/___ MM DD YYYY	**HPV Dose 2** ___/___/___ MM DD YYYY	**HPV Dose 3** ___/___/___ MM DD YYYY
Meningococcal B **(Serogroup B)** **Type:**____________	**Men B Dose 1** ___/___/___ MM DD YYYY	**Men B Dose 2** ___/___/___ MM DD YYYY	**Men B Dose 3** ___/___/___ MM DD YYYY
Varicella Vaccine **Or Varicella Blood test titer** (equivocal or negative results are not acceptable)	**Varicella Dose 1** ___/___/___ MM DD YYYY	**Varicella Dose 2** ___/___/___ MM DD YYYY	**Varicella Titer** ***attach copy of lab results** ___/___/___ MM DD YYYY

TB SCREENING: ALL students **MUST** fill out the enclosed TB screening questionnaire, and receive laboratory testing prior to arrival on campus if indicated. **Quantiferon gold or T- Spot** will be accepted. ***Attach a copy of lab results** ___/___/___

MM DD YYYY

Health Care Provider :

Printed Name:____________________**Signature:**____________________________

Address: ______________________________**Phone :(____)** __________**Fax :(____)** __________

Student: Please do not mail, fax, or email a copy of your immunization records as they will not be processed without being accompanied with a completed Juniata College Immunization Verification Form.

PROVIDER:

Provide this completed form and a copy of any blood titer tests confirming immunity to the student.

STUDENT:

Have Medical provider complete form and turn into Health Services at orientation.

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

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: ____________________