

JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEET

We suggest you make a copy of this form for your records. Student to complete page 1; health care provider to complete all subsequent pages. All health forms must be returned by August 1.

_____	_____	_____	_____	_____	_____
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 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 service 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 medications? 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 it will be destroyed.**

JUNIATA COLLEGE IMMUNIZATION VERIFICATION FORM

LAST NAME	FIRST NAME	DATE OF BIRTH (MM/DD/YYYY)
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REQUIRED VACCINES:

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)
 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:
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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: _____
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Polio (Required) Completed Primary series of immunization? Yes ___ No ___
Date of last booster: ___/___/___ Type: OPV ___ IPV ___ EP-IPV MM DD YYYY

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

JUNIATA COLLEGE IMMUNIZATION VERIFICATION FORM

HIGHLY RECOMMENDED IMMUNIZATION:

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 tester 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 PDF or lab results.**

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/_____	Height R____/____	L____/_____

Normal Abnormal Explain:

#	System	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.

<p>Gynecological History</p> <p>Menstruation age of onset: _____; lasts _____ day; regular <input type="checkbox"/> every _____ days; irregular <input type="checkbox"/></p> <p>Pain: never <input type="checkbox"/> sometimes <input type="checkbox"/> always <input type="checkbox"/> Usual treatment of pain _____</p>

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	Kenya	Niger	South Korea
Algeria	Congo	Kiribati	Nigeria	South Sudan
Angola	Core d'Ivoire	Kuwait	Niue	Sir Lanka
Argentina	Democratic Republic of the Congo	Kyrgyzstan	North Korea	Sudan
Armenia	Djibouti	Laos	Pakistan	Suriname
Azerbaijan	Dominican Republic	Latvia	Palau	Swaziland
Bahrain	Ecuador	Lesotho	Panama	Tajikistan
Bangladesh	El Salvador	Liberia	Papua New Guinea	Tanzania
Belarus	Equatorial Guinea	Libya	Paraguay	Thailand
Belize	Eritrea	Lithuania	Peru	Timor-Leste
Benin	Estonia	Madagascar	Philippines	Togo
Bhutan	Ethiopia	Malawi	Poland	Trinidad and Tobago
Bolivia	Fiji	Malaysia	Portugal	Tunisia
Bosnia and Herzegovina	Gabon	Maldives	Qatar	Turkey
Botswana	Gambia	Mali	Romania	Turkmenistan
Brazil	Georgia	Marshall Islands	Russia	Tuvalu
Brunei Darussalam	Ghana	Mauritania	Rwanda	Uganda
Bulgaria	Guatemala	Mauritius	St Vincent & the Grenadines	Ukraine
Burkina Faso	Guinea	Mexico	Sao Tome and Principe	Uruguay
Burundi	Guinea-Bissau	Micronesia	Senegal	Uzbekistan
Cabo Verde	Haiti	Moldova	Serbia	Vanuatu
Cambodia	Honduras	Mongolia	Seychelles	Venezuela
Cameroon	India	Mozambique	Sierra Leone	Viet Nam
Central African Republic	Indonesia	Myanmar	Singapore	Yemen
Chad	Iran	Namibia	Solomon Islands	Zambia
China	Iraq	Nauru	Somalia	Zimbabwe
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 above questions is NO, no further testing or action is required.

Student Name: _____ DOB _____