

JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEET

(To be completed by student – we suggest you make a copy of this 4 page form for your records)

_____ Last Name	_____ First name	_____ MI	_____ Date of Birth	_____ 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:

#	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.

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	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.

Student Name _____

Date _____