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****

1. MEASLES, MUMPS, RUBELLA: Two immunizations for measles and one each for mumps and rubella are **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 needed if first dose given prior to age 16

3. T-dap booster: (**Required** within last 10 years) _____/______/______

4. HEPATITIS B: (Highly Recommended)
Dose 1______/______/______ Dose 2______/______/______ Dose 3______/______/______

5. VARICELLA: history of disease (year) ________ OR vaccine dates: _____/_____/_____; _____/_____/______

6. POLIO: (Highly Recommended) Completed primary series of polio immunization? yes ____ no _____
Date of last booster: ______/______/______ Type: OPV _____ IPV ______ EP-IPV _______

7. HEPATITIS A: (Recommended) 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)

____
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 People's Republic of Korea
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
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
St Vincent& Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
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.