ASBURY UNIVERSITY
Academic Excellence & Spiritual Vitality

Student Health Services

One Macklem Drive Wilmore, KY 40390 ● Phone (859)858-3511 Ext 2277●Fax 859-858-0003

REPORT OF MEDICAL HISTORY

M ❑ F ❑ Sex

Single ❑ Married ❑ Other ❑ Marital Status

Last Name (Please print) First Middle Cell Phone

Home Address (Number and Street) City State Zip Code Country

Date of Birth Place of Birth Date you plan to enroll

In case of emergency contact:_____

Name (Please print) Address Relationship

Home Telephone Cell Phone

HEALTH INSURANCE: REQUIRED FOR ALL CURRENTLY ENROLLED STUDENTS

Are you covered under a family policy?_____

Name of Company Group Number Policy Number

PPO/HMO? Referral needed? Primary care provider/phone number

Please attach front and back copies of your insurance card.

Do you plan to purchase the student health insurance available at time of registration? YES_____ NO_____

Important: *During financial registration, students are also required to enter their personal or family health insurance information OR sign up for Asbury University's Student Health Insurance plan. Information about this plan is available at* ***http://www.asbury.edu/student-life/health-services/student-health-insurance.***

Please note: *All currently enrolled full time students have access to health care at the University Health Service regardless of insurance coverage. Insurance is for services* ***not*** *available at the University Health Service, such as x-rays, lab tests, specialists or hospitalizations.*

 (The following health history is confidential. It does NOT affect your admission status, and is NOT a part of your academic records.)

Physical and dental exams are not required, but strongly recommended. If you have an on-going physical or mental condition, please attach additional pages of appropriate information from your family physician and/or most recent physical.

FAMILY HISTORY

Have any members of your family or blood relatives ever had:

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Tuberculosis				Heart Disease			
Diabetes				Kidney Disease			
Psychiatric Illness				Hypertension (High Blood Pressure)			
Cancer				Epilepsy			
Obesity				Any chronic illness not listed			

PERSONAL HEALTH HISTORY *(History of previous/current illness)*

ALLERGY TO MEDICATION: Penicillin _____ Sulfa _____ Aspirin _____ Others _____

Ht_____ Weight_____ Blood Pressure and date taken _____

	√	YEAR / Comment		√	YEAR / Comment
Chickenpox			Eating Disorder		
Hepatitis			Headaches (recurrent or migraine)		
Malaria			Heart murmur/disease		
Mononucleosis			Insomnia		
Tuberculosis			Joint disease or injury		
Allergies (seasonal)			Kidney stones		
Anemia			Learning disorders/ADD/ADHD		
Asthma			Pregnancy		
Back problems			Seizures		
Blood sugar (high/low)			Sexually Transmitted Infections		
Blood Pressure (high/low)			Shortness of Breath		
Cancer (specify)			Skin rashes/acne		
Chronic Cough			Stomach or intestinal trouble		
Concussion			Tumor or cysts		
Depression/anxiety			Other:		
Dizziness/fainting					
Ear, nose, throat trouble					

Hospitalizations, surgeries, outpatient surgeries? Give date and diagnosis _____

Medications taken regularly?_____Allergy injections? _____

Medical disability?_____Need special housing?_____Sports participation limited?_____

Have you received treatment or counseling for an emotional problem, depression, or anxiety? Give details and supply additional medical records if indicated:_____

_____

_____

MENINGOCOCCAL AND HEPATITIS B VACCINATION STATUS FORM, page 3 of 5

(form completion required by student)

Effective June 20, 2005, the State of Kentucky requires all postsecondary education institutions with residential campuses to provide vaccination information on meningococcal meningitis disease to full-time students living in residential housing, including documentation of meningococcal vaccination status. The law does not require that students be vaccinated, although it is strongly recommended. The law also requires institutions to provide first time, full-time students with information about hepatitis B disease. The intent of this legislation is to educate young adults on the risks of meningococcal disease and hepatitis B and to encourage prevention by vaccination.

Meningococcal (Bacterial) Meningitis is a rare but very serious disease that can cause severe swelling of the brain and spinal cord, and can lead to a life threatening blood infection. The most common early symptoms of meningitis are similar to the flu—high fever, severe headache, stiff neck, nausea and vomiting, lethargy and a rash. Because the disease progresses rapidly, often in as little as 12 hours, students are urged to seek medical care immediately if they experience two or more of these symptoms concurrently. The bacteria is transmitted through close, direct contact with the oral secretions of an infected person, such as by sharing glasses or utensils, kissing and coughing.

A vaccine (Menactra) is available that protects against four of the five most common strains of the bacteria that cause meningitis, providing protection for approximately 5 years. The National Centers for Disease Control and Prevention (CDC) and the American College Health Association (ACHA) recommend that college students receive the vaccine—especially those in dormitories, creating higher risk because of living in close proximity to each other. The vaccine is available through physician offices, clinics, and pharmacies. For more information on meningitis: www.cdc.gov/meningitis/ or www.nmaus.org

Hepatitis B is a viral infection of the liver that can cause jaundice, permanent liver damage, liver cancer and even death. Signs and symptoms vary, but can include fever, fatigue, nausea & vomiting, weight loss, abdominal pain and dark urine. A person can be infected both directly through infected blood or body fluids and indirectly by coming in contact with surfaces or objects contaminated with the virus. The virus can be contracted through sexual contact, needle sticks, sharing of an infected person's toothbrush, razor or earrings, through cuts and scrapes during contact sports, piercing or tattooing. Hepatitis B is 100 times more contagious than HIV (the virus that causes AIDS). It can stay alive on contaminated surfaces for as long as a month.

Fortunately, hepatitis B is preventable by a vaccine series consisting of three shots given over a 6-month time period. The National Centers for Disease Control and Prevention (CDC) and the American College Health Association (ACHA) strongly recommend that all college students receive the vaccine. This vaccine is also available through physician offices, clinics, and pharmacies.

For more information on hepatitis B: www.cdc.gov/hepatitis/HBV.htm

*****PLEASE COMPLETE THE MENINGOCOCCAL AND HEPATITIS B VACCINATION STATUS FORM BELOW (*REQUIRED FOR STUDENTS RESIDING IN RESIDENCE HALLS).* YOU ARE NOT REQUIRED TO HAVE EITHER VACCINATION, BUT YOU MUST DISCLOSE YOUR VACCINATION STATUS.** If you would like to get the vaccinations or have questions about whether you should be vaccinated, please talk with your family doctor or call Student Health Services at 859/858-3511, x2277 for local resources.

Meningococcal Vaccine	Received	☐Yes
		☐No
Hepatitis B	Received	☐Yes
		☐No

I, the undersigned student (parent, if under 18 years of age) have read and understand the information provided to me about meningococcal meningitis and hepatitis B.

I understand the benefits and risks of being vaccinated against these diseases. The information above regarding my/my student's vaccination status is accurate and is being provided in compliance with ***Kentucky Code Sections 164.282 and 164.2867.***

Signature of student _____ Date _____

Signature of Parent (**IF STUDENT IS UNDER AGE 18)** _____ Date _____

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Based on the guidelines published by The American College Health Association's recommendations from the Centers of Disease Control (CDC) and the American Thoracic Society, ***Tuberculosis screening is required*** ***within the last six months*** *primarily by conducting a Risk Assessment. For more information,* ***visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis at*** www.cdc.gov/tb/pubs/corecurr/index.htm.

				/ /
Last Name	*First Name*	*Middle Initial*	*Maiden Name*	*Date of Birth (mo / date / year)*

1	**Do you have any of the following signs or symptoms of active tuberculosis disease?** • Productive cough greater than three weeks duration, unexplained weight loss, or night sweats	❒ **Yes** ❒ **No**
2	**Are you a member of a high risk group?** ⇨have HIV infection or inject drugs; ⇨have had close contact with someone with infectious TB disease; or have resided in, volunteered in or worked in high risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters ⇨have clinical conditions such as diabetes, leukemias or lymphomas, low body weight, gastrectomy and jejunoilial bypass, chronic malabsorption syndromes, chronic renal failure, prolonged corticosteroid therapy (e.g. prednisone > 15 mg/d for > 1 month), or other immunosuppressive disorders.	❒ **Yes** ❒ **No**
3	**Have you lived in or traveled in countries where TB is endemic?** (Significance of travel exposure should be evaluated.) *(Includes those students who have arrived within the past 5 years from countries* ***other than*** *those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia (USA), Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand)*	❒ **Yes** ❒ **No**

If you answer "yes" to any of the above questions, a TB skin test is needed prior to your arrival on campus
The test should be administered no sooner than 9 weeks after working in, or traveling to a high-risk TB area. Should your travel be less than 9 weeks ago, you may have your test done at Asbury's Student Health Service. Please indicate the country visited, the length of time spent in the high-risk TB area, and the date you returned _____

_____
Signature of Student | Date | Signature of Parent/Guardian if student is under age 18

PHYSICIAN: PLEASE USE THE SPACE BELOW TO DOCUMENT TUBERCULIN SKIN TESTING AND/OR CHEST RADIOGRAPHY *(based on assessment criteria outlined above)*

A. TB SKIN TEST	**Date Administered:**		**Date Read:**	**Reaction in Millimeters:**	_____ **mm induration**
	Interpretation (based on mm of induration as well as risk factors):			❒ **Positive**	❒ **Negative**
B. CHEST X-RAY* (req'd w/in 6 months of entry for positive PPD or if PPD not placed, but student is at risk of disease			**Date of Chest X-ray:**	**Result*:** ❒ **Normal**	❒ **Abnormal**
❒ INH initiated	Date: _____ x _____ months		INH course completed?	❒ **Yes**	❒ **No**

Chest x-ray report and follow-up records by health care professional must be attached to Medical History Form.

Physician's Signature	Please Print Name	Date

Street Address	City	State	Zip	Telephone	Fax

REQUIRED IMMUNIZATIONS

TO STUDENT**: ***This completed form must be submitted prior to registration for your first semester at Asbury University. This requirement may be met in one of two ways:

- ❒ Have a physician complete this form, which then can be returned by mail or faxed to Student Health Services.
- ❒ Obtain a copy of your complete immunization record from your high school, Health Department, or physician's office & attach it to your health history form.

Student's Information

				- -	/ /
Last Name	First Name	Middle Initial	Maiden Name	Social Security Number	Date of Birth

Physician's Information *(please read carefully, as boosters may be needed to meet requirements)*

****REQUIRED IMMUNIZATIONS****	mo / date / year	mo / date / year	mo / date / year	mo / date / year	mo / date / year
A. **MMR** (measles, mumps, rubella): *2 doses required after twelve months of age*	**#1:**	**#2:**			
B. **TETANUS & DIPHTHERIA**: 1. *Primary series of at least four doses with DtaP or DTP* 2. *Tetanus-Diphtheria-Pertussis (Tdap) Booster given within last 10 years*	**#1:**	**#2:**	**#3:**	**#4:**	**#5:**
C. **POLIO**: *Primary series of at least three doses*	**#1:**	**#2:**	**#3:**	**#4:**	**#5:**
D. **REQUIRED TUBERCULOSIS SCREENING and/or TB SKIN TEST (Mantoux PPD), within six months of entry:** *please see page 4 for TB screening tool*					

STRONGLY RECOMMENDED (NOT REQUIRED) IMMUNIZATIONS	mo / date / year	mo / date / year	mo / date / year
A. **HEPATITIS B:** *Three doses or positive surface antibody* 1. Immunization 2. HepB surface antibody ☐reactive ☐non-reactive	**#1:**	**#2:**	**#3:**
B. **MENINGOCOCCAL**: *One dose recommended for students under age 25, particularly students living in residence halls (check one)* ☐ Menomune ☐ Menactra			
OTHER IMMUNIZATION HISTORY	**mo / date / year**	**mo / date / year**	**mo / date / year**
A.	**#1:**	**#2:**	**#3:**
B.	**#1:**	**#2:**	**#3:**
C.	**#1:**	**#2:**	**#3:**

(Affix Stamp Here)

Medical Provider's Signature Date

Address (or affix stamp in box at left) Phone

Print Name of Medical Provider