



MEDICAL FORM & IMMUNIZATION RECORD

Name (PRINT) LAST FIRST MIDDLE Date of Birth / / M F

Home Address City ST ZIP

Parents/Guardian/Spouse Home Phone ()

IN CASE OF EMERGENCY, notify Work Phone ()

Name of Personal Physician Address Phone No.

Entering Year (Fr) (So) (Jr) (Sr) Transferring from another university? (Y) (N) School Name

STUDENTS: This form must be completed, returned and verified by Student Health Services personnel by July 10. Satisfactory completion of this process is required before you can register for classes. MAIL TO: Student Health Services, Medical Records, Furman University, 3300 Poinsett Highway, Greenville, SC 29613-5133. For more information please call 864.294.2180.

PLEASE READ CAREFULLY BEFORE COMPLETING THIS FORM

IMPORTANT: Legal safeguards make it necessary for each student to have a medical, physical and immunization record on file in the Health Services Office. The physical examination is not available through Furman's Health Services.

The primary purpose of this medical record is to provide a basic point of reference in case of future illness, to identify any medical condition requiring attention before it interferes with your studies, and to provide the Health Services staff with knowledge of any necessity for ongoing treatment. All information revealed will be considered confidential and will not interfere with your enrollment into the university unless such findings would endanger other students or staff. Furman University Student Health Center is HIPAA compliant.

Allergy injections will be administered by Student Health staff with appropriate allergists' recommendations and for a nominal fee.

Paul V. Catalana, M.D., M.P.H. Medical Director, Student Health Services

NOTICE OF PRIVACY PRACTICES - Please read and sign this statement.

Furman University Student Health Center complies with HIPAA (Private Practices) regulations. A full list of these regulations may be found on our website, www.furman.edu/healthservice, posted throughout the Health Center, or available in print upon request. Federal law requires that we inform you of this privacy statement.

I acknowledge that I have been informed of Furman University Student Health Services Notice of Privacy Practices.

Student Signature Print Student Name Date Signed

INSURANCE INFORMATION

ALL students are required to have health insurance coverage either under parent/dependent or student plan (available through Furman). IF INSURED, please complete.

Student Name DOB SS#

Parent (Insured) Name DOB SS#

ATTACH A COPY OF FRONT AND BACK OF INSURANCE CARD.

***PARENT(s) - We recommend that you check with your insurance company to be certain your student will be insured while residing at Furman University.

IF NOT INSURED, please sign: My son/daughter WILL NOT BE INSURED BY MY INSURANCE.

A. FAMILY MEDICAL HISTORY

	AGE	OCCUPATION	STATE OF HEALTH	IF DECEASED AGE AT DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers					
Sisters					

List family history and relationship to you of any disease such as diabetes, hypertension, heart disease, cancer, etc. _____

B. HEALTH HISTORY – If you have ever had any of the following conditions or symptoms, please place check mark in appropriate box.

<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Chicken Pox Yr _____	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Irritable Bowel Disease	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Stone	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Drug/Alcohol Problem	<input type="checkbox"/>	Malaria	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	Thyroid problem
<input type="checkbox"/>	Blood Disorder/Anemia	<input type="checkbox"/>	Eye Injury or Disease	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Bone/Joint Problems	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	Ulcer – Stomach or Duodenal
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Urinary Infections/Problems
<input type="checkbox"/>	Cardiac Problem	<input type="checkbox"/>	Hepatitis (jaundice)	<input type="checkbox"/>	Recurrent Bronchitis	<input type="checkbox"/>	Other
<input type="checkbox"/>	Chest Pain/Shortness of Breath	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Recurrent Sinusitis	<input type="checkbox"/>	

FEMALES ONLY		<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	Breast Mass
<input type="checkbox"/>	Female Surgery	<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	Severe Cramps

Are you on medication for cramps or regulation of periods? No ___ Yes ___ If so, name _____

Explain conditions checked _____

- Are you currently taking medication for any of the above? No ___ Yes ___ If so, explain and name medication _____
- Do you have any drug allergies? No ___ Yes ___ If so, name drug _____
- Do you have any other allergies? No ___ Yes ___ If so, explain _____
- Have you ever been admitted to a hospital? No ___ Yes ___ If so, please give name of hospital, date and reason for admission. _____
- Do you have any physical challenges or conditions that may impact your activity (Ex. physical education or ROTC participation)? No ___ Yes ___
If so, explain _____
- Have you ever had treatment for nervous or emotional problems? No ___ Yes ___ If so, explain _____
By whom were you treated _____ Address _____
If medication used for treatment, name _____

AIDS: In accordance with the recommendations and guidelines of the U.S. Public Health Service, all students with AIDS or with a positive HIV (AIDS) antibody test are directed to report this fact to the University Health Services as soon as they arrive on campus. Confidentiality will be maintained. Counseling and medical care for these students are available.

PARENTAL PERMIT - *If student under 18 years of age.*

Law requires parental permission before operative procedures on minors. No operation will be performed except in extreme emergency without parents being notified. To care for such emergencies, it is requested that the parent sign the following: *I hereby authorize the medical staff and its consultants to prescribe and perform any emergency procedure on my son/daughter* _____.

_____/_____
Parent Signatue Date

PARENTAL NOTIFICATION

YES _____ NO _____

I permit Furman University medical staff and its consultants to notify my parents or guardian in the event of an emergency or serious illness.

_____/_____
Student Signatue Date

IMMUNIZATION RECORD

Name _____ DOB ____/____/____ SS # ____/____/____
(Last) (First) (Middle)

Furman University **REQUIRES** the following immunizations upon the recommendation of the American College Health Association, South Carolina Department of Health and U.S. Public Health.

THIS SECTION MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

ALL DATES MUST INCLUDE MONTH, DAY AND YEAR

1. M.M.R. (Measles, Mumps, Rubella) – *Two doses required.*
Dose #1 given at age 12-15 months or later #1 ____/____/____
Dose #2, given at least one month after first dose or later #2 ____/____/____

If given as single doses, please record below:

a. Measles – Two doses required as noted above for M.M.R. #1 ____/____/____ #2 ____/____/____
b. Mumps.....#1 ____/____/____, Booster, if received #2 ____/____/____
c. Rubella#1 ____/____/____, Booster, if received #2 ____/____/____

2. TETANUS-DIPHTHERIA (Primary series with DtaP or DTP and booster with TD in the last 10 years meets requirements).
#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____
Td BOOSTER – Tetanus-Diphtheria (Td) within the last 10 years..... Date ____/____/____

3. POLIO (OPV, IPV or IPV/OPV) [Circle one] Primary series in childhood meets requirement.
#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____ #5 ____/____/____

4. HEPATITIS B (Three doses of vaccine, or two doses of adult vaccine in adolescents 11-15 years of age, or positive Hep B surface antibody)
a. Vaccine DatesDose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
b. Hepatitis B surface antibody..... Test Date ____/____/____ Results Reactive ____ Non-Reactive ____ (Attach a copy of report).

5. VARICELLA (Either history of chickenpox, positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 12 years; only one dose required if given before age 12)
a. History of chickenpox: Yes ___ No ___ Year ____ b. Varicella vaccine given Dose #1 ____/____/____ Dose #2 ____/____/____
c. Varicella antibody..... Test Date ____/____/____ Results Reactive ____ Non-Reactive ____ (Attach a copy of report).

6. MENINGOCOCCAL Recommended (One dose preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease.
Meningococcal Vaccine..... Date ____/____/____ Lot# _____

7. PNEUMOCOCCAL POLYSACCHARIDE VACCINE (One dose for members of high risk groups)..... Date ____/____/____

8. INFLUENZA (Annual immunization recommended to avoid disruption of academic activities).....Date of last Dose ____/____/____

9. TUBERCULOSIS SCREENING *See explanation of (a) and (b) on next page (4).
a. Does this student have signs or symptoms of active tuberculosis disease? Yes ___ No ___ If no, skip to (b). If YES, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin test, chest x-ray and sputum evaluation as indicated.
b. Is the student a member of a high-risk group or is the student entering the health professions? Yes ___ No ____ . If No, stop. If yes, place a tuberculin skin test (Mantoux only). A history of BCG vaccination should not preclude testing of a member of a high-risk group.
c. Tuberculin skin Test Given ____/____/____, Date Read ____/____/____, Result _____ mm. (Record actual induration.)
Interpretation (based on mm. of induration as well as risk factors): Positive ____ Negative ____
d. Chest X-ray (required if tuberculin skin test is positive): Date of x-ray ____/____/____ Normal ____ Abnormal ____ (Attach copy of report)

HEALTH CARE PROVIDER: I certify that the above information is correct.

Signature _____ MD, NP, RN, or _____ Date ____/____/____
Print/Stamp Name _____ Telephone (____) _____
Address _____ City _____ State _____ Zip _____

- (a) The American College Health Association has published guidelines on tuberculosis screening for college students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr.
- (b) Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, student should undergo TB screening if they have arrived from countries EXCEPT 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. Other categories of high-risk students include those with HIV infection, who inject drugs, who 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; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy, (e.g., prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.

PHYSICAL EXAMINATION

A. LABORATORY DATA – (Required for ALL students)

Hemoglobin or Hematocrit _____ Urinalysis: Sugar _____, Protein _____ . Cholesterol (Optional) _____
 Height _____ Weight _____ B/P _____ Pulse _____
 Visual Acuity: Uncorrected _____ Corrected _____ (Circle One): Glasses Contact Lens Both

B. PHYSICIAN'S EVALUATION

1. Date of examination ____/____/____ Name of Physician (Print) _____
2. Physical examination is within normal limits. (Yes) (No) If abnormal, please explain and attach copy of your report.

3. Have you treated this student for any significant disease or medical problem other than minor short term illness? (No) (Yes)
Please explain _____
4. Is this student currently under your care and on medication? (No) (Yes) If so, please explain _____

5. Does this student have drug allergies? (No) (Yes). If yes, list _____
6. How can we be of assistance to you in the care of your patient? (Attach copy of evaluation and recommendations) or explain –

7. Do you consider this student physically and emotionally capable of handling college academics/life? (Yes) (No) (Doubtful).
Give reasons for No or Doubtful _____
8. In your opinion is he/she physically qualified for: (*Circle*) [Unrestricted] – [Restricted] athletics, exercise or walking?
a. If restricted, list basis for restriction _____
b. Is restriction permanent? (No) (Yes) Temporary? (No) (Yes) How long? _____
9. Does student have any food allergies? (No) (Yes) If yes, list _____
10. Is student on a special diet or other dietary considerations? (Yes) (No) If yes, explain _____

 Signature of Examining Physician Telephone # (_____) _____ Fax # (_____) _____
 Address _____ City _____ State _____ ZIP _____