

HARDIN - SIMMONS UNIVERSITY

STUDENT HEALTH FORM *To be completed by HSU applicants.*

Name _____ Student ID # _____ Student Cell Phone: () - _____
Birth Date / / Start Term at HSU Fall Spring Year: _____
Have you attended HSU previously? No Yes (sem, yr) _____

Health Insurance Information (International Students required to have health insurance)

Health Insurance Company _____ Phone () _____
Street Address _____ City _____ State _____ Zip _____
Subscriber's Name _____ Subscriber's number _____ Group ID # _____
Employer _____

Immunization Records:

It is required by law for all incoming first-time and/or transfer students under 22 years old to have received the Meningococcal Vaccine within 5 years before the first class day and at least 10 days prior to first class day.

MPSV or MCV4 Date Administered ____/____/____
MMR (Measles, Mumps, Rubella) (Two doses for students born after 1/1/57)
1st Date ____/____/____ 2nd Date ____/____/____
Tetanus Diphtheria (Within the last 10 years) Date of Last TD or Tdap Vaccine: ____/____/____
Polio (not required past age 19) Date of completed series ____/____/____
Varicella: Date of 1st injection ____/____/____ Date of 2nd injection ____/____/____
(Chickenpox) History of disease: ____ Yes ____ No
Hepatitis B Dates of injections 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____
Hepatitis A/B (combined) Dates of injections 1st ____/____/____ 2nd ____/____/____ 3rd ____/____/____
Hepatitis A Dates of injections 1st ____/____/____ 2nd ____/____/____

To authenticate immunizations provider should complete the information below or attach copies of immunization records.

Health Care Provider's Signature (M.D., RN, LVN, or P.A.) _____ Date: ____/____/____
Provider's Title: _____ Provider's Phone #: _____
Provider's Address: _____
Street Address _____ City _____ State _____ ZIP _____

Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? Yes No
Were you born in one of the countries listed on the next page that have a high incidence of active TB disease? Yes No
(If yes, please CIRCLE the country, on the next page)
Have you had frequent or prolonged visits* to one or more of the countries listed on the next page with a high prevalence of TB disease? (If yes, CHECK the countries, on the next page.) Yes No
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, Hardin-Simmons University requires that you receive TB testing no more than 6 months prior to starting class.

If the answer to all the above questions is NO, no further testing or further action is required, and you may skip to page 3.

*The significance of the travel exposure should be discussed with a health-care provider and evaluated.

Afghanistan	Côte d'Ivoire	Japan	Nicaragua	Sudan
Algeria	Croatia	Kazakhstan	Niger	Suriname
Angola	Democratic People's Republic of	Kenya	Nigeria	Swaziland
Argentina	Korea	Kiribati	Pakistan	Syrian Arab Republic
Armenia	Democratic Republic of the	Kuwait	Palau	Tajikistan
Azerbaijan	Congo	Kyrgyzstan	Panama	Thailand
Bahrain	Djibouti	Lao People's Democratic	Papua New Guinea	The former Yugoslav
Bangladesh	Dominican Republic	Republic	Paraguay	Republic of
Belarus	Ecuador	Latvia	Peru	Macadonia
Belize	El Salvador	Lesotho	Philippines	Timor-Leste
Benin	Equatorial Guinea	Liberia	Poland	Togo
Bhutan	Eritrea	Libyan Arab Jamahiriya	Portugal	Tunisia
Bolivia (Plurinational State of)	Estonia	Lithuania	Qatar	Turkey
Bosnia and Herzegovina	Ethiopia	Madagascar	Republic of Korea	Turkmenistan
Botswana	Fiji	Malawi	Republic of Moldova	Tuvalu
Brazil	Gabon	Malaysia	Romania	Uganda
Brunei Darussalam	Gambia	Maldives	Russian Federation	Ukraine
Bulgaria	Georgia	Mali	Rwanda	United Republic of
Burkina Faso	Ghana	Marshall Islands	Saint Vincent and the	Tanzania
Burundi	Guam	Mauritania	Grenadines	Uruguay
Cambodia	Guatemala	Mauritius	Sao Tome and Principe	Uzbekistan
Cameroon	Guinea	Micronesia (Federated States	Senegal	Vanuatu
Cape Verde	Guinea-Bissau	of)	Seychelles	Venezuela (Bolivarian
Central African Republic	Guyana	Mongolia	Sierra Leone	Republic of)
Chad	Haiti	Morocco	Singapore	Viet Nam
China	Honduras	Mozambique	Soloman Islands	Yemen
Colombia	India	Myanmar	Somalia	Zambia
Comoros	Indonesia	Namibia	South Africa	Zimbabwe
Congo	Iraq	Nepal	Sri Lanka	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of > 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata>

Tuberculin Skin Test (if required from page 1, if not required skip to page 3)

TB Skin Test: Date Given ____/____/____ Date Read ____/____/____ Result: _____mm **Interpretation: positive____ negative____
(month / day / year) (month / day / year) (induration) (Based on mm induration as well as risk factors.)

Chest X Ray: (Required if TB Skin Test is positive) Date Read ____/____/____ Result: normal____ abnormal____
(month / day / year)

****Interpretation guidelines of TB Skin Test**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Health Care Professional's Signature: _____ Date: ____/____/____

Title: _____ Phone #: _____

Health Care Professional's Address: _____
Street Address City State Zip

If you've had a positive TB Skin Test in the past and been treated for Latent Tuberculosis Infection please provide proper documentation including dates and treatment with this health form.

Medical History

Migraine Headaches	No <input type="checkbox"/> Yes, Date <input type="checkbox"/> _____	Anemia	No <input type="checkbox"/> Yes, Date <input type="checkbox"/> _____	Ear/Nose/Throat	No <input type="checkbox"/> Yes, Date <input type="checkbox"/> _____
Frequent Headaches	<input type="checkbox"/> <input type="checkbox"/> _____	Pneumonia	<input type="checkbox"/> <input type="checkbox"/> _____	Problems	
Visual Disorders/ Eye Trouble	<input type="checkbox"/> <input type="checkbox"/> _____	Shortness of Breath	<input type="checkbox"/> <input type="checkbox"/> _____	Hepatitis	<input type="checkbox"/> <input type="checkbox"/> _____
Heart Disorder	<input type="checkbox"/> <input type="checkbox"/> _____	Asthma	<input type="checkbox"/> <input type="checkbox"/> _____	Arthritis	<input type="checkbox"/> <input type="checkbox"/> _____
Diabetes	<input type="checkbox"/> <input type="checkbox"/> _____	Chest Pains	<input type="checkbox"/> <input type="checkbox"/> _____	Menstrual Disorder	<input type="checkbox"/> <input type="checkbox"/> _____
Epilepsy	<input type="checkbox"/> <input type="checkbox"/> _____	Chicken Pox	<input type="checkbox"/> <input type="checkbox"/> _____	Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/> _____
Cancer	<input type="checkbox"/> <input type="checkbox"/> _____	Seizures	<input type="checkbox"/> <input type="checkbox"/> _____	Encephalitis	<input type="checkbox"/> <input type="checkbox"/> _____
Vertigo/Dizziness	<input type="checkbox"/> <input type="checkbox"/> _____	Eating Disorders	<input type="checkbox"/> <input type="checkbox"/> _____	Meningitis	<input type="checkbox"/> <input type="checkbox"/> _____
Hypertension	<input type="checkbox"/> <input type="checkbox"/> _____	Frequent Worry/ Nervousness	<input type="checkbox"/> <input type="checkbox"/> _____	Head Injury	<input type="checkbox"/> <input type="checkbox"/> _____
Stomach Disorder	<input type="checkbox"/> <input type="checkbox"/> _____	Frequent Anxiety	<input type="checkbox"/> <input type="checkbox"/> _____	Fainting	<input type="checkbox"/> <input type="checkbox"/> _____
		Frequent Depression	<input type="checkbox"/> <input type="checkbox"/> _____	Liver Problems	<input type="checkbox"/> <input type="checkbox"/> _____
				Kidney Disorder	<input type="checkbox"/> <input type="checkbox"/> _____

Comments on yes replies: _____

Please detail any condition you are now receiving treatment for (attach additional paper if needed). _____

Surgical History List surgery(s) and date(s) of occurrence

Physical Disabilities Briefly describe any physical disabilities

Allergies List known allergic disorders and identify reactions to foods, drugs, or contact agents

Current Medications List prescription medication(s) with dosages you are currently taking on a routine basis

MEDICAL TREATMENT CONSENT I authorize the University Nurse and/or consultants to administer medical services, immunizations, and therapeutic procedures as deemed necessary, or to refer to licensed medical personnel when indicated (including nearby hospitals).

Student's signature if 18 or older Date ____/____/____

Parent/Guardian Signature if Student under 18 Date ____/____/____

Please sign below that you received written **"Important Information about Bacterial Meningitis"** with this form.

Signature _____

Date ____/____/____

IMPORTANT INFORMATION ABOUT BACTERIAL MENINGITIS (for student to keep)

This information is being provided to all new college students in the state of Texas. Bacterial Meningitis is a serious, potentially deadly disease that can progress extremely fast- so take utmost caution. It is an inflammation of the membranes that surround the brain and spinal cord. The bacteria that causes meningitis can also infect the blood. This disease strikes 1,000 to 3,000 Americans each year, including 100-125 on college campuses, leading to 5-15 deaths among college students every year. There is a treatment, but those who survive may develop severe health problems or disabilities.

WHAT ARE THE SYMPTOMS?

- High fever
- Rash or purple patches on skin
- Light sensitivity
- Confusion and sleepiness
- Lethargy
- Severe headache
- Vomiting
- Stiff neck
- Nausea
- Seizures

There may be a rash of tiny, red-purple spots caused by bleeding under the skin. These can occur anywhere on the body. The more symptoms, the higher the risk, so when these symptoms appear seek immediate medical attention.

HOW IS BACTERIAL MENINGITIS DIAGNOSED?

- Diagnosis is made by a medical provider and is usually based on a combination of clinical symptoms and laboratory results from spinal fluid and blood tests.
- Early diagnosis and treatment can greatly improve the likelihood of recovery.

HOW IS THE DISEASE TRANSMITTED?

The disease is transmitted when people exchange saliva (such as by kissing, or by sharing drinking containers, utensils, cigarettes, toothbrushes, etc.) or come in contact with respiratory or throat secretions.

HOW DO YOU INCREASE YOUR RISK OF GETTING BACTERIAL MENINGITIS?

- Exposure to saliva by sharing cigarettes, water bottles, eating utensils, food, kissing, etc.
- Living in close conditions (such as sharing a room/suite in a dorm or group home).

WHAT ARE THE POSSIBLE CONSEQUENCES OF THE DISEASE?

- Death (in 8 to 24 hours from perfectly well to dead)
- Permanent brain damage
- Kidney failure
- Learning disability
- Hearing loss, blindness
- Limb damage (fingers, toes, arms, legs) that requires amputation
- Gangrene
- Coma
- Convulsions

CAN THE DISEASE BE TREATED?

- Antibiotic treatment, if received early, can save lives and chances of recovery are increased. However, permanent disability or death can still occur.
- Vaccinations are available and should be considered for those living in close quarters and college students 25 years old or younger.
- Vaccinations are effective against 4 of the 5 most common bacterial types that cause 70% of the disease in the U.S. (but does not protect against all types of meningitis).
- Vaccinations take 7- 10 days to become effective.
- The cost of vaccine varies, so check with your health care provider.
- Vaccination is very safe. Most common side effects are redness and minor pain at injection site for up to 2 days.
- Vaccination is available at the Taylor County Health Department located at 850 North 6th Street, Abilene, TX. Phone (325) 692-5600.

HOW CAN I FIND OUT MORE INFORMATION?

- Contact your own health care provider.
- Contact HSU Student Health Center at Moody Center Rm. 208. Ext. 1314
- Contact your local or regional Tex. Dept. of Health office. In Abilene contact the Taylor County Health Department at 850 North 6th Street. Phone (325) 692-5600.
- Visit: www.cdc.gov/ncidod/dbmd/diseaseinfo or www.acha.org