How to use fill-in PDF E-Forms

GEORGIA SOUTHWESTERN STATE UNIVERSITY

HERSCHEL A. SMITH HEALTH CENTER
800 Wheatley Street * Americus, GA 31709
(229) 931-2235 fax (229) 931-2666
email: health@canes.gsw.edu
www.gsw.edu/~health/

Please reset the form after you have printed it!

HEALTH HISTORY AND IMMUNIZATION RECORD

The University requires a medical history and updated immunizations. The information on this health form is confidential and will be used only as an aid to providing necessary health care while you are a student. You will not be permitted to register until this completed form has been received by the Herschel A. Smith Health Center. Please submit form at least four weeks before registration.

PRINT FORM RESET FORM

PERSONAL DATA (PLEASE PRINT IN INK OR TYPE)

1. Full Name _____
2. Student ID _____ SS# _____
3. Sex M ◯ F ◯ 4. Age ____ 5. Birth Date _____ 6. Height _____ 7. Present weight ____ lbs
8. Marital Status S ◯ M ◯ D ◯ W ◯ 9. Mothers Maiden name: _____
10. Home Address _____ 11. Telephone _____
12. E-mail address _____
13. Name of your parent/guardian _____ Telephone _____
16. Parent/guardian's mailing address _____
17. Person to contact in an emergency _____ 18. Telephone _____
19. University division/school you are entering _____ 19. Date Entering _____

MEDICAL HISTORY

1. List medication to which you are allergic and give dates and descriptions of reactions. (If "none" please indicate.)

_____

2. List and give dates (by occurrence or onset) of any major illnesses or hospitalizations you have had. (If "none" please indicate.)

_____

3. List and give dates of significant injuries or surgery. (If "none" please indicate)

_____

4. List medication you are taking. (Including oral contraceptives, allergy injections, herbals, etc. -If "none" please indicate.)

_____

5. Do you smoke? Yes ◯ No ◯ Previously? Yes ◯ No ◯ How long? _____ How much per week? _____
6. Do you drink alcoholic beverages? Yes ◯ No ◯ Previously? Yes ◯ No ◯ How long? _____ How much per week? _____
7. Are you concerned about your use of alcohol, tobacco, or drugs? Yes ◯ No ◯
8. Are you satisfied with your present weight? Yes ◯ No ◯ Have you had a significant weight change recently? Yes ◯ No ◯
9. What, if any, restriction do you have on your physical activites? _____
10. Is there any other information which would be helpful to the Herschel A. Smith Health Center in providing you with medical care?

_____

STUDENT NAME _____

DO YOU HAVE A PRESENT OR PAST HISTORY OF:

(Check Every Item)

Yes	No		Yes	No	
		Eye Problems			Congenital birth defects
		Ear/Nose/Sinus Problems			Cancer or malignancy
		Throat/tonsillar infections			Non-malignant tumor
		Infectious Mononucleosis			Thyroid Disorder
		Asthma			Diabetes
		Bronchitis			Epilepsy or seizures
		Tuberculosis			Headaches
		Other lung infection			Depression
		Rheumatic Fever			Anxiety or tendency to worry
		Heart murmur			Skin problems
		Chest pain			Measles(Red/Rubeola)
		Rapid heart rate			Measles(German/Rubella)
		Fainting during or after exercise			Mumps
		Ulcer (stomach/duodenal)			Chicken pox
		High blood pressure			Gynecological Problems
		Recurrent diarrhea			Herpes/other genital infections
		Colitis/Enteritis			Back Problems
		Hepatitis: Type			Bone or Joint Problems
		Bladder or kidney infection			Sports-related injuries
		Kidney Stone			Alcohol or Drug Use
		Anemia or blood disorder			Eating Disorder
		Blood clotting problems			Other

IF YES IS ANSWERED TO ANY OF THE ABOVE, PLEASE EXPLAIN AND PROVIDE DATES, TREATMENTS, AND COMPLICATIONS, ETC.

FAMILY HISTORY

Are both of your parents living? Yes ◯ No◯ If no, cause of death _____

If alive, are your parents in good health? Yes ◯ No◯ If no, please explain. _____

Number of siblings: Living Deceased Cause of death

Has any member of your family now or in the past had:

	Yes	No	Relation to you		Yes	No	Relation to you
Heart Disease				High Blood Pressure			
Cancer				Psychiatric Disorders			
Diabetes				Alcohol/Drug abuse			

PREVIOUS MEDICAL HISTORY

List the name and address of your family or home physician/primary care provider:
Name _____ Telephone _____

Address:

STUDENT NAME_____

Immunization Record

PART I (To be completed and signed by a health care provider. Dates must include month, day, and year.)

Required Immunizations:

A. MMR (measles, mumps, and rubella) required for students born in 1957 or later)

1._____Dose 1 - immunized at 12 months of age or later, (MO/DA/YR)_____/_____/_____ **AND**
2._____Dose 2 - immunized at least 30 days after Dose 1 (MO/DA/YR)_____/_____/_____

OR

MEASLES

1._____had disease, confirmed by physician diagnosis in office record, OR (MO/DA/YR)_____/_____/_____
2._____born before 1957 and therefore considered immune, OR (MO/DA/YR)_____/_____/_____
3._____has laboratory evidence of immune titer (specify date), OR (MO/DA/YR)_____/_____/_____ (copy of lab required)
4._____immunized with live measles vaccine at 12 mths. of age or later, (MO/DA/YR)_____/_____/_____ **AND**
5._____immunized with second dose of live measles vaccine at least 30 days after 1st one (MO/DA/YR)_____/_____/_____

MUMPS

1._____had disease, confirmed by physician diagnosis in office record, OR (MO/DA/YR)_____/_____/_____
2._____born before 1957 and therefore considered immune, OR (MO/DA/YR)_____/_____/_____
3._____has laboratory evidence of immune titer (specify date), OR (MO/DA/YR)_____/_____/_____ (copy of lab required)
4._____immunized with live measles vaccine at 12 mths. of age or later (MO/DA/YR)_____/_____/_____

RUBELLA

1._____has laboratory evidence of immune titer (specify date), OR (MO/DA/YR)_____/_____/_____ (copy of lab required)
2._____immunized with live measles vaccine at 12 mths. of age or later (MO/DA/YR)_____/_____/_____

B. TETANUS-DIPHTHERIA –required of all students

1._____Completion of primary series (DTaP, DTP or TD) within the last ten years prior to matriculation **OR**
2._____**TETANUS** Booster within the past 10 years – (MO/DA/YR)_____/_____/_____

C. VARICELLA – required for all students

1._____Documented history of Varicella (Chicken Pox) Yes No **OR**
2._____Laboratory /serologic evidence of immunity **OR**
3._____Dose 1 – immunization date (MO/DA/YR)_____/_____/_____ given at 12 months of age or later but before the 13th birthday **OR**
4._____2 Doses. Dose 1 given after the student's 13th birthday. 2nd dose at one month after first dose (MO/DA/YR)_____/_____/_____

D. HEPATITIS B- required of all students who are 18 years of age or younger. (Three doses of vaccine or a positive surface antibody)

Dose 1 - (MO/DA/YR)_____/_____/_____ Dose 2 - (MO/DA/YR)_____/_____/_____ Dose 3 - (MO/DA/YR)_____/_____/_____ **OR**

Combined Hepatitis A and hepatitis B series:

Dose 1 - (MO/DA/YR)_____/_____/_____ Dose 2 - (MO/DA/YR)_____/_____/_____ Dose 3 - (MO/DA/YR)_____/_____/_____ **OR**

2 doses hepatitis B series of Recombivax:

Dose 1 - (MO/DA/YR)_____/_____/_____ Dose 2 - (MO/DA/YR)_____/_____/_____ **OR**

Laboratory/serologic evidence of immunity or prior infection

E. MENINGOCOCCAL-vaccination or waiver required of students residing in campus housing

1._____immunized with meningococcal vaccine (MO/DA/YR)_____/_____/_____

F. TB (Mantoux) SKIN TEST –required of International and ELI Students within 10 days of arrival to GSW campus.

Date placed (MO/DA/YR):_____/_____/_____ Date read:_____/_____/_____ mm induration_____
Chest X-ray (Required if PPD positive) Date:_____ (please attach a copy of the CXR report in English) Normal_____ Abnormal_____
Have you been treated with anti-tubercular drugs? Yes_____ No_____ Type of Treatment:_____Length of treatment:_____

G. Exemption

_____This student is exempt from the above immunization on grounds of permanent medical contraindication
_____This student is temporarily exempt from the above immunization until_____ /_____/_____

Vaccinations recommended:

H. **POLIO** Dose 1 – most recent dose (MO/DA/YR)_____/_____/_____

I. **HEPATITIS A** Dose 1 – (MO/DA/YR)_____/_____/_____ **AND** Dose 2 - (MO/DA/YR)_____/_____/_____

Health Care Provider

Name_____ **Address**_____

Signature_____ **State**_____**Zip**_____

Date_____ **Phone**_____

Part II-Exemptions

I affirm that immunization as required by the University System of Georgia is in conflict with my religious beliefs. I understand that I am subject to exclusion in the event of an outbreak of a disease for which immunization is required.

I declare that I will be enrolling in ONLY courses offered by distance learning. I understand that if I register for a course that is offered on-campus or at a campus-managed facility this exemption becomes void and I will be excluded from class until I provide proof of immunizations.

Signature_____ DATE_____

Signature_____ DATE_____

(Parent or Guardian Signature if student is under 18)

Revised 07/04

THIS SECTION TO BE COMPLETED BY STUDENT

MENINGITIS IMMUNIZATION WAIVER

Student ID: _____ **Social Security Number** _____

Name _____

Address _____
Street **City** **State** **Zip**

Year/Term you plan to enroll _____ / _____ **Date of Birth** _____ / _____ / _____

In keeping with the law I, _____ acknowledge I have
(Print name)
received a vaccination against meningococcal disease, OR reviewed the information provided to me by the institution

Signature_____DATE _____

Signature_____DATE _____
(Parent or Guardian Signature if student is under 18)

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HEALTH INSURANCE INFORMATION *(Required for international and ELI students)*

(Please attach a copy of your insurance card along with its policy limits to this form)

INSURANCE COMPANY _____ **POLICY NUMBER** _____

ADDRESS _____ **NAME OF POLICY HOLDER** _____

_____ **SS# OF POLICY HOLDER** _____

☐ **PLEASE CHECK THIS BOX OF YOU ARE NOT CURRENTLY INSURED BUT YOU INTEND TO BUY THE GSW ENDORSED STUDENT HEALTH INSURANCE PLAN.**

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CONSENT FOR TREATMENT AND STATEMENT OF ACCURACY

I hereby authorize the medical staff at Georgia Southwestern State University Health Services, their agents or consultants to perform diagnostic and treatment procedures which in their judgment become necessary while I am a student at Georgia Southwestern State University. I also authorize such treatment, x-rays or other diagnostic studies as, in the judgment of the provider, may be reasonably necessary to preserve and protect my health (or the health of my minor child or ward).

By my signature below, I also attest that all statements in the student medical and immunization record are true to the best of my knowledge and that I(or for my minor child or ward) have (has) no health problems or medical restrictions not listed on this record.

PRINT FORM RESET FORM

SIGNATURE OF STUDENT_____**DATE**_____

If student is under 18 years of age, this form must be signed by the parent or guardian:

SIGNATURE OF PARENT OR GUARDIAN_____**DATE** _____

Please be certain that all questions are answered, all signatures are completed (including the signature of your healthcare provider) and that you have met all applicable Georgia Southwestern State University Immunization Requirements. Mail this form to:
Georgia Southwestern State University Herschel A. Smith Health Center 800 Wheatley Street
Americus, GA 31709

This space below is reserved for use by GSW Student Health Services Personnel only.

Reviewed By:_____**Date reviewed:**_____**Date completed:** _____

Comments_____

Date(s) deficiency notice(s) sent _____

Revised 07/04

Meningococcal Disease Information

The Georgia General Assembly passed legislation requiring public and nonpublic postsecondary educational institutions to give students residing in campus housing information about meningococcal disease and vaccine. Students are required to sign a document provided by the postsecondary institution stating that they have received a vaccination against meningococcal disease or reviewed the information and declined to be vaccinated. The governor signed the legislation on May 28, 2003; effective January 1, 2004 (Official Code of Georgia Annotated § 31-12-3.2). Please carefully read the information below and sign the attached waiver form and return as directed.

Meningococcal Disease Facts

Meningococcal disease is a serious infection caused by bacteria, most commonly causing meningitis (an infection of the membranes that surround the spinal cord and brain) or sepsis (an infection of blood that affects many organ systems).

College freshmen, particularly those living in dorms, have a modestly increased risk of getting the disease compared with other persons of the same age. Up to 100 cases occur among the 15 million college students in the United States each year, with 5-15 deaths. However, the overall risk of disease, even among college students, is low.

Crowded living conditions and smoking (active or passive) are additional risk factors that are potentially modifiable.

Bacteria are spread from person-to-person through secretions from the mouth and nose, transmitted through close contact. Casual contact or breathing in the same air space is not considered sufficient for transmission.

Common symptoms include: stiff neck, headache, fever, sensitivity to light, sleepiness, confusion, and seizures. Invasive meningococcal disease, or blood infection with the organism, causes fever and rash.

The disease can be treated with antibiotics, but treatment must be started early. Even with treatment, some patients may die. Survivors may be left with a severe disability such as the loss of a limb.

A meningococcal polysaccharide vaccine is available for those who wish to pay for it.
Vaccine protects against 4 of the 5 most common types of meningococcal bacteria and protection typically lasts 3-5 years.

Vaccination may decrease the risk of meningococcal disease; however, it does not eliminate the risk because the vaccine does not protect against all types of meningococcal bacteria. Approximately 50-70% of disease among college students is likely to be vaccine-preventable.

Vaccine may be available at travel clinics, health departments, student health services, or through private providers. Prices may vary. The meningitis vaccine is available at the Herschel A. Smith Health Center at a nominal cost for students enrolled at GSW.

Information about meningococcal disease:
The availability of a safe and effective vaccine http://www.cdc.gov/nip/publications/VIS/vis-mening.pdf
a listing of additional sources of information http://www.cdc.gov/nip/recs/teen-schedule.htm#chart
a map of Georgia's public health districts http://www.usg.edu/student services/immun/resources map.pdf
GSW Health Center: http://www.gsw.edu/~health/

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