FURMAN

MEDICAL FORM & IMMUNIZATION RECORD

Name _____ Date of Birth ____/___/____ M ___ F ___

(PRINT) LAST FIRST MIDDLE

Home Address _____ City _____State _____ ZIP _____

Parents/Guardian/Spouse _____ Home Phone (___) _____ - _____

IN CASE OF EMERGENCY, notify _____ Work Phone (___) _____ - _____

Student Cell Ph# (___) ____ - _____ Mother Cell Ph# (___) _____ - _____ Father Cell Ph# (___) _____ - _____

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 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.*

Dr. Jill Golden, M.D.
Medical Director, Student Health Services

INSURANCE INFORMATION -Please complete and attach a copy of front and back of medical insurance card.
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 _____ SS # _____/___/_____

Primary Insured Name _____ Ins. ID# _____

Name of Insurance Company_____ Group #_____

****ATTENTION PARENT**(s) -We recommend verifying with your insurance company of your student's coverage while at Furman.

IF NOT INSURED, please sign: My son/daughter ***WILL NOT BE INSURED***. _____

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

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 Signature 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 Signature Date

A. FAMILY MEDICAL HISTORY

	AGE	Occupation	State of Health	If Deceased: Age at Death	If Deceased: Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					

List family history and relationship to you of any disease such as diabetes, Hypertension, heart disease, Cancer, etc.

B. PERSONAL HEALTH HISTORY

-If **you (student)** have ever had any of the following conditions or symptoms, please place check mark in appropriate box.

	ADD/ADHD		Chicken Pox		High Blood Pressure		Rheumatic Fever
	Anxiety		Depression		Irritable Bowel Disease		Seizures
	Arthritis		Diabetes		Kidney Stone		Sexually Transmitted Disease
	Asthma		Drug/Alcohol Problem		Malaria		Skin problems
	Back Problems		Eating Disorder		Migraine Headaches		Thyroid problem
	Blood Disorder/Anemia		Eye Injury or Disease		Mononucleosis		Tuberculosis
	Bone/Joint Problems		Frequent Headaches		Neurological Disorder		Ulcer -Stomach or Duodenal
	Cancer		Heart Murmur		Pneumonia		Urinary Infections/Problems
	Cardiac Problem		Hepatitis (Jaundice)		Recurrent Bronchitis		Other
	Chest Pain/Shortness of Breath		Hernia		Recurrent Sinusitis		
FEMALES ONLY			Abnormal Pap Smear		Breast Mass		
	Ovarian Cyst		Irregular Periods		Severe Cramps		

Are you on medication for cramps or regulation of periods? No __ Yes __ If Yes, Name of Medication and Dosage _____

Explain conditions checked

_____

_____

Are you currently taking any medications? No __ Yes __ If so, list names _____

_____

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 or had any surgical procedures? 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 mental health issues such as Depression, Anxiety, or Mood Disorder? No ___ Yes ___ If so, explain

_____

By who 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.

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

A. 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 28 days after first dose..... #2 ____ / ____ / _____

B. TETANUS-DIPHTHERIA (Primary series with DTaP, DTP or DT, and booster with TD or Tdap in the last 10 years meets requirements).

1. Primary series of four doses with DTaP, DTP,DT, or Td: **REQUIRED**

#1 ____ / ____ / _____ #2____ / ____ / _____#3 ____ / ____ / _____ #4 ____ / ____ / _____

2. Booster: Tdap (preferred) to replace single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient m ___ /d___/ yr___

3. Booster: Td within the last ten years **REQUIRED**……m ___/ d___/yr ___

C. POLIO (OPV, IPV or IPV/OPV) [Circle one] Primary series in childhood meets requirement. **REQUIRED**

#1 ____ / ____ / _____ #2____ / ____ / _____#3 ____ / ____ / _____ #4 ____ / ____ / _____ #5 ____ / ____ / _____

D. 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) **REQUIRED**

a. Vaccine Dates ....Dose #1 ____ / ____ / _____ Dose #2 ____ / ____ / _____ Dose #3 ____ / ____ / _____

b.

b. Hepatitis B surface antibody .....Test Date __/__ /__ Results Reactive __ Non-Reactive __ *(Attach* a *copy of report).*

E. VARICELLA (A history of chickenpox, a positive Varicella antibody, or two doses of vaccine meets requirements.) **REQUIRED**

a. History of chickenpox: Yes __ No __ b. Immunization: Dose #1 ____ / ____ / ____
Dose #2 ____ / ____ / ____

c. Varicella antibody..... Test Date ____ / ____ / ____ Results Reactive __ Non-Reactive __ *(Attach* a *copy of report)*

F. MENINGOCOCCAL TETRAVALENT Highly Recommended

Tetravalent Conjugate (CMCV-4)..... Date ____ / ____ / ____

Tetravalent Polysacchride (MPSV-4) Acceptable if conjugate not available; revaccinate every 3-5 years for increased risk……Date ___/ ___/ _____

G. HEPATITIS A –Recommended

1. Immunization (hepatitis A)
2. a. Dose #1 ___/ ___/ ___ b. Dose #2 ___/___/___

H. PNEUMOCOCCAL POLYSACCHARIDE VACCINE Recommended

(One dose for members of high risk groups)..... Date ____ / ____ / _____

I. INFLUENZA Recommended (Trivalent inactivated influenza vaccine, TIV, or live attenuated influenza vaccine, LAIV)

Date of last Dose _____ / _____ / _____ TIV ___ LAIV ___

J. Quadrivalent Human Papillomavirus Vaccine (HPV) – Recommended

(Three doses of vaccine for female college students 11-26 years of age years of age at 0, 2 and 6 month intervals.)

Dose #1 ___/ ___/ ___ Dose #2 ___/___/___ Dose # 3 ___/___/___

TUBERCULOSIS (TB) SCREENING/ TESTING (REQUIRED)

Please answer *ALL* the following questions:

Have you ever had a positive TB skin test? Yes ____ No ____

Have you ever had close contact with anyone who was sick with TB? Yes ____ No ____

Where you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes____ No ____

(If yes please circle the country below)

Have you ever traveled to/in one or more of the countries listed below? Yes ____ No ____

(If yes please check the country/ies)

Have you ever been vaccinated with BCG? Yes ____ No ____

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei
Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea DPR
Korea Republic
Kuwait
Kyrgyzstan
Loa PDR
Latvia
Lesotho
Liberia
Lithuania
Macedonia TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritius
Mexico
Micronesia
Moldova Rep
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
ST Vincent & The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Syrian Arab Rep
Swaziland
Tajikistan
Tanzania UR
Thailand
Timor Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Islands
W Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

If the answer is YES to any of the above questions, Furman University requires that a health care provider complete a 1 step PPD test.

See form on next page.

TUBERCULOSIS (TB) RISK ASSESSMENT *cont. Please answer All of the following questions*

1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0".
The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y
Result: _____ mm of induration **Interpretation: positive____ negative____

3. Chest x-ray: (Required if TST or IGRA is positive)
Date of chest x-ray: ____/____/____ Result: normal____ abnormal____

****Interpretation guidelines**
>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
• Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist
• Persons with HIV/AIDS
>10 mm is positive:
• Persons born in a high prevalence country or who resided in one for a significant amount of time*
• History of illicit drug use
• Mycrobacteriology laboratory personnel
• History of resident, worker or volunteer in high-risk congregate settings
• Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
>15 mm is positive:
• Persons with no known risk factors for TB disease

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone ( ) _____