DEPAUW *HEALTH*

STUDENT HEALTH RECORD 2015

1000 E. Main St., Building 1, Suite 106, Danville, IN 46122
PHONE 765.658.4555 FAX 317.718.8160
VISIT www.DePauwHealth.org
To drop off on campus: Student Life Office, Union Bldg., Rm. 210

Please complete and submit to DePauw Student Health Services by July 1. Failure to submit the complete Student Health Record and provide proof of immunizations may result in cancellation of student's classes.

PERSONAL INFORMATION

Student Name: _____ Sex: ☐Male ☐Female
Last name First name Middle name

Date of Birth: _____/_____/_____ Allergies: _____

Medications: _____

Student Cell Phone Number: _____ Country of Residence _____

STATEMENT OF HEALTH

Please list any health care concerns, including any ongoing or significant past medical or psychological conditions:

_____

_____

_____

_____

Requests for medical/religious vaccine exemptions must be submitted to the DePauw Student Health Services.

MENINGITIS VACCINE

Meningococcal meningitis is a rare, but potentially fatal bacterial infection that can result in inflammation of the membranes surrounding the spinal cord and brain as well as infection directly into the bloodstream. Permanent disabilities can result even if the individual survives the infection. Since students residing in residence halls are at higher risk for contacting this infection, it is recommended that college students be educated about meningococcal meningitis and the benefits of vaccination.

A vaccine is available that protects against most types of bacteria which cause this infection. DePauw Student Health Services can administer this vaccine for a fee which is billed to the student's account, or you may choose vaccination from your family physician prior to arrival at DePauw. We recommend this vaccination although it is not a requirement. Parents and students are welcome to contact our office for more information or consult our Web site at DePauwHealth.org.

Student's Signature: _____ Date: _____

Parent's Signature**: _____ Date: _____

** *Parent signature **required only** for students that enter DePauw University before their 18th birthday.*

Name: _____

IMMUNIZATIONS: This form must be completed in its entirety for all required items.

To be completed by a licensed health care provider.

A. **M.M.R. (Measles, Mumps, Rubella)**: Two doses *required*. #1 _____/_____ (M Y) #2 _____/_____ (M Y)

B. **Tetanus-Diptheria**: Booster *required* within 10 years.

Primary series:

#1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y) #4 _____/_____ (M Y) #5 _____/_____ (M Y)

Td or Tdap Booster: _____/_____ (M Y)

C. **Tuberculosis (TB) Screening Questionnaire**. Please check all that apply:

☐Have been in close contact with someone who has TB, or currently have symptoms of acute TB infection.

☐Have traveled to or was born in a country * that has endemic TB.

☐Have a chronic medical problem that puts me at risk for TB or other high risk factors*.

* Please see www.cdc.gov for endemic countries and high risk groups.

If you have checked any of the above, you need a TB skin test or serology within six months prior to travel to campus. If you have ever had a positive TB test, you will need a chest x-ray within six months prior to arrival to campus.

Serology: Date _____/_____/_____ (M D Y) Result: _____ OR

TB skin test: Date Placed _____/_____/_____ (M D Y) Date Read _____/_____/_____ (M D Y) Result _____ mm of induration

Please attach a chest x-ray report if TB skin test 10mm or greater, or if serology is positive.

D. **Polio**: At least three doses recommended.

#1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y) #4 _____/_____ (M Y) #5 _____/_____ (M Y)

E**. Varicella**: Recommended for those without history of active disease.

Antibody: ____/_____ (M Y) ☐Reactive ☐Non-reactive ☐ History of disease Immunization: #1 _____/_____ (M Y) #2 _____/_____ (M Y)

F**. Hepatitis B**: Highly recommended for all students #1 _____/_____ (M Y) #2 _____/_____ (M Y) #3 _____/_____ (M Y)

Hepatitis B surface antibody: _____/_____ (M Y) ☐Reactive ☐Non-reactive

G. **Hepatitis A**: Recommended for travelers. #1 _____/_____ (M Y) #2 _____/_____ (M Y)

H. **Meningococcal Meningitis**: Two doses recommended for undergraduates living in residence halls.

Quadrivalent polysaccharide vaccine: # 1 _____/_____ (M Y) # 2 _____ /_____ (M Y)

I. Other Immunizations: (Please list)

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

Health Care Provider must sign below or a copy of an official immunization record must be attached.

Name: _____

Signature: _____ Phone: _____