

# UNIVERSITY OF MOUNT UNION HEALTH RECORD

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
LAST FIRST MIDDLE

Address \_\_\_\_\_  
ADDRESS CITY STATE ZIP CODE

Date of Birth \_\_\_\_\_ Biological Sex M \_\_\_ F \_\_\_ Gender Identity \_\_\_\_\_

Student's Cell Phone \_\_\_\_\_

Person to Notify in an Emergency \_\_\_\_\_  
(Relationship)

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

## FAMILY HEALTH HISTORY

CHECK EACH ITEM	YES	NO	RELATIONSHIP	CHECK EACH ITEM	YES	NO	RELATIONSHIP
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>		ASTHMA, HAY FEVER, HIVES	<input type="checkbox"/>	<input type="checkbox"/>	
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>		EPILEPSY OR CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	
HIGH BLOOD PRESSURE/STROKE	<input type="checkbox"/>	<input type="checkbox"/>		NERVOUS OR MENTAL DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	
HEART TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>		BLEEDING/CLOTTING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	
CANCER	<input type="checkbox"/>	<input type="checkbox"/>		OTHER	<input type="checkbox"/>	<input type="checkbox"/>	

## PERSONAL HEALTH HISTORY

Have you ever had or do you now have any of the following (In lines of multiple statements, cross out the inapplicable words.):  
 Explain all answers below.

CHECK EACH ITEM	Yes	No	CHECK EACH ITEM	Yes	No	CHECK EACH ITEM	Yes	No
ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	MIGRAINE HEADACHE	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	TOBACCO USE	<input type="checkbox"/>	<input type="checkbox"/>
HEART PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS/ JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	DEPRESSION/ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>
SKIN PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	ORTHOPEDIC PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	MUMPS	<input type="checkbox"/>	<input type="checkbox"/>
ALLERGIES/HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES/CONVULSIONS	<input type="checkbox"/>	<input type="checkbox"/>	SURGERY	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOL/DRUG ABUSE	<input type="checkbox"/>	<input type="checkbox"/>
THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY/BLADDER	<input type="checkbox"/>	<input type="checkbox"/>
STOMACH OR BOWEL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>

If yes, or any other medical conditions or physical limitations, give details \_\_\_\_\_

Check Each Item	Yes	No	If yes, list:
Do you take medication?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you allergic to any medications or latex?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Are you allergic to any foods?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**STATEMENT OF AUTHORIZATION**

Authorization is hereby granted, for the health and welfare of the student, for the Physician or Physician Assistant to admit him/her to the hospital if necessary, and to refer this student to any duly licensed physician or surgeon when indicated. Permission is given to administer any medication, treatment, vaccines, etc., deemed necessary by the Health Center staff.

\_\_\_\_\_  
 Signature of Student Date

\_\_\_\_\_  
 Signature of Parent/Guardian (if student is under 18 years of age) Date

# UNIVERSITY OF MOUNT UNION HEALTH RECORD

Student \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

**PRIMARY INSURANCE: Please include copy of insurance card- front and back.**

Name of Policy holder \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Relationship of insured to student \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

Member ID \_\_\_\_\_ Group No. \_\_\_\_\_

**SECONDARY INSURANCE: Please include copy of insurance card- front and back.**

Name of Policy holder \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Relationship of insured to student \_\_\_\_\_

Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

Member ID \_\_\_\_\_ Group No \_\_\_\_\_

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### **Part I: 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

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

Have you had frequent or prolonged visits\* to one or more of the countries or territories listed below with a high prevalence of TB disease? (If yes, CHECK the countries or territories, below)  Yes  No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)  Yes  No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of  $\geq 20$  cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

**If the answer to all of the above questions is NO, no further testing or further action is required.**

**If the answer is YES to any of the above questions, the University of Mount Union requires that you receive TB testing as soon as possible.**

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

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Part II. Clinical Assessment by Health Care Provider**

Clinicians should review and verify the information in Part I of Page 3. **Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.**

History of a positive TB skin test or IGRA blood test? (If yes, document below)      **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

History of BCG vaccination? (If yes, consider IGRA if possible.)      **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

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**1. TB Symptom Check**

**Does the student have signs or symptoms of active pulmonary tuberculosis disease?**      **Yes** \_\_\_\_\_ **No** \_\_\_\_\_

If No, proceed to 2 or 3

**If yes, check below:**

- Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- Coughing up blood (hemoptysis)
- Chest pain
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

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 \_\_\_\_

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_      Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
                          M    D    Y                                    M    D    Y

Result: \_\_\_\_\_ mm of induration      \*\*Interpretation: positive \_\_\_\_ negative \_\_\_\_

**\*\*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 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.

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

**3. Interferon Gamma Release Assay (IGRA)**

Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ (specify method) QFT-GIT T-Spot other\_\_\_\_  
M D Y

Result: negative\_\_\_\_ positive\_\_\_\_ indeterminate\_\_\_\_ borderline\_\_\_\_ (T-Spot only)

Date Obtained: \_\_\_\_/\_\_\_\_/\_\_\_\_ (specify method) QFT-GIT T-Spot other\_\_\_\_  
M D Y

Result: negative\_\_\_\_ positive\_\_\_\_ indeterminate\_\_\_\_ borderline\_\_\_\_ (T-Spot only)

**4. Chest x-ray: (Required if TST or IGRA is positive)**

Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: normal\_\_\_\_ abnormal\_\_\_\_  
M D Y

**Part III. Management of Positive TST or IGRA**

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- Infected with HIV
- Recently infected with *M. tuberculosis* (within the past 2 years)
- History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- Have had a gastrectomy or jejunioileal bypass
- Weigh less than 90% of their ideal body weight
- Cigarette smokers and persons who abuse drugs and/or alcohol

\_\_\_\_\_ Student agrees to receive treatment

\_\_\_\_\_ Student declines treatment at this time

\_\_\_\_\_  
Health Care Professional Signature

\_\_\_\_\_  
Date

# UNIVERSITY OF MOUNT UNION HEALTH RECORD

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please complete this form indicating your immunization history or include a copy of your immunization record, which includes the mandatory immunizations.

**\*MANDATORY IMMUNIZATIONS REQUIRED BY THE UNIVERSITY OF MOUNT UNION  
INCLUDE TWO DOSES OF MMR (MEASLES, MUMPS, AND RUBELLA) OR TITERS SHOWING IMMUNITY, AND A TDAP  
WITHIN THE LAST 10 YEARS.**

**All other immunizations are highly recommended**

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
<b>Dtap</b> Diphtheria, Tetanus, Pertussis					
<b>*Tdap</b> *Within 10 years					
<b>*MMR – 2 doses</b> Measles, mumps, rubella					
<b>Varicella</b> Chicken Pox					
<b>Hepatitis B</b>					
<b>Hepatitis A</b>					
<b>Meningococcal</b>					
<b>HPV</b> Human Papillomavirus					
<b>Influenza</b> Most Recent					
<b>IPV/OPV</b> <b>Polio</b>					
<b>Other</b>					

### Information Needed for the Office of Residence Life

\*In order to comply with an Ohio law, which went into effect July 1, 2005, any student planning on living on campus must be informed of the risk associated with and the benefits of vaccination for meningitis and hepatitis B. In accordance with this law, we are providing you with the link to the Ohio Department of Health website ([www.odh.ohio.gov](http://www.odh.ohio.gov)) for further information.

Please note that this law does not require vaccination, nor does it require the institution to provide or pay for these vaccines. It requires only disclosure of whether or not you have been vaccinated.

Your signature below will suffice as a release for the Health Center to be able to share the information regarding only those immunizations with the Office of Residence Life, should the need arise.

\_\_\_\_\_ (signature and date)