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	❑	❑		ASTHMA	❑	❑	
DIABETES	❑	❑		EPILEPSY OR CONVULSIONS	❑	❑	
HIGH BLOOD PRESSURE	❑	❑		NERVOUS OR MENTAL DISORDER	❑	❑	
HEART TROUBLE	❑	❑		BLEEDING/CLOTTING DISORDER	❑	❑	
CANCER	❑	❑		OTHER	❑	❑	

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	❑	❑	BLOOD DISORDER	❑	❑	COVID-19 | Date: _____	❑	❑
RHEUMATIC FEVER	❑	❑	DIABETES	❑	❑	MIGRAINE HEADACHE	❑	❑
HEART PROBLEMS	❑	❑	HEPATITIS/ JAUNDICE	❑	❑	DEPRESSION/ANXIETY	❑	❑
SKIN PROBLEMS	❑	❑	ORTHOPEDIC PROBLEMS	❑	❑	MUMPS	❑	❑
ALLERGIES/HAY FEVER	❑	❑	SEIZURES/CONVULSIONS	❑	❑	SURGERY	❑	❑
ARTHRITIS	❑	❑	HIGH BLOOD PRESSURE	❑	❑	ALCOHOL/DRUG ABUSE	❑	❑
THYROID PROBLEMS	❑	❑	HIV	❑	❑	KIDNEY/BLADDER	❑	❑
STOMACH OR BOWEL PROBLEMS	❑	❑	TUBERCULOSIS	❑	❑	ADHD/ADD	❑	❑

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

Check Each Item	Yes	No	If yes, list:
Do you take medication?	❑	❑	_____
Are you allergic to any medications or latex?	❑	❑	_____
Are you allergic to any foods?	❑	❑	_____

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**

PLEASE RETURN TO UNIVERSITY OF MOUNT UNION, HEALTH CENTER, 1972 CLARK AVENUE, ALLIANCE, OH 44601

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 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** _____

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 jejunoileal 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

PLEASE RETURN TO UNIVERSITY OF MOUNT UNION, HEALTH CENTER, 1972 CLARK AVENUE, ALLIANCE, OH 44601

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
Dtap Diphtheria, Tetanus, Pertussis					
***Tdap** *Within 10 years					
***MMR – 2 doses** Measles, mumps, rubella					
Varicella Chicken Pox					
Hepatitis B					
Hepatitis A					
Meningococcal					
HPV Human Papillomavirus					
Influenza Most Recent					
IPV/OPV Polio					
COVID-19 Manufacturer					

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) 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)