HEALTH & IMMUNIZATION FORM

WORCESTER STATE UNIVERSITY

Mail completed form to:

Worcester State University
Student Health Services
486 Chandler Street, Worcester, MA 01602

Phone: 508-929-8875
Fax: 508-929-8075

Please check all appropriate boxes:

☐ Commuter ☐ Campus resident ☐ First Year ☐ Graduate ☐ Transfer
☐ Athlete ☐ IELI ☐ Exchange ☐ Nursing, OT, CD Status: ☐ PT ☐ FT

1. GENERAL INFORMATION: TO BE COMPLETED BY STUDENT

Legal Name_____
Last First Middle

Chosen Name (optional)_____

Birthdate_____ Birthplace_____
Month Day Year

Sex Assigned at Birth: ☐ Male ☐ Female ☐ Decline to State

State Gender Identity: ☐ Male ☐ Female ☐ Transgender Man ☐ Transgender Woman ☐ Gender Non-Conforming ☐ Not Listed ☐ Decline to State

Permanent Home Address:_____
No. Street

_____
City State Zip

Home Phone (_____)_____ Student's Cell# (_____)_____

Parents's Name _____ Parents's Name _____
Last First Middle Last First Middle

Home Address_____ Home Address_____
No. Street No. Street

_____ _____
City State Zip City State Zip

Home Phone (_____)_____ Home Phone (_____)_____

Business Phone (_____)_____ Business Phone (_____)_____

Someone other than parents to be notified in case of emergency (if parents are unavailable):

Name_____ Phone Number (_____)_____

Address_____

Do you have any allergy to medication? ☐ Yes ☐ No

Please list:_____

Do you have any serious medical condition? ☐ Yes ☐ No

If yes, please explain: _____

FOR OFFICE USE ONLY

University Address_____

University Telephone #_____

II. MEDICAL HISTORY

Please complete this form before going to your physician for examination.

Have you ever had or have you now a problem with (check at right of each item): *(Explain YES answers below)*

Check each item:	Yes	No		Yes	No		Yes	No		Yes	No
Head & nervous system			Poor teeth/toothaches			Hepatitis or jaundice			Exposure to DES		
Headaches			Gum Disease			Genitourinary system			Infectious disease		
Fainting			Heart, Lungs			Blood in urine			Mononucleosis		
Severe head injury			High blood pressure			Cystitis			Chicken pox		
Seizures/convulsions			Heart murmur			Kidney infection/disease			TB or positive skin test		
Dizzy spells			Heart trouble			Menstrual disorder			Past illnesses		
Insomnia			Palpitations			Bones, joints			Operations		
Eyes			Shortness of breath			Fractures/dislocations			Serious injuries		
Blindness			Chronic cough			Knee problems			Serious illness		
Double vision			Pneumonia			Deformity			Substance abuse		
Deafness, hearing aid			Asthma			Arthritis			Psychological illness		
Perforated eardrum			Bronchitis			Back problems			Medication allergy —		
Frequent ear infections			Digestive system			Tumor or growth			please list:		
Frequent nose bleeds			Abdominal pain			Skin disorder					
Frequent sore throats			Diarrhea; chronic/recurrent			Diabetes					
Neck			Colitis, ileitis			High cholesterol			Other Allergies:		
Frequent swollen glands			Irritable bowel			Eating disorder					
Thyroid dysfunction			Gall stones			Sickle cell trait/disease					

Explanation of YES answers:_____

_____

_____

III. PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER.

To the health care provider: Please review the student's history and complete the physician's form. The information is strictly for the use of Health Services and will not be released without student consent.

Name:_____
Last First Middle

Height:_____ BP:_____/_____ Right Vision_____ Left Vision_____

Weight:_____ Pulse:_____ Resp:_____ ☐ Glasses: Right Vision_____ Left Vision_____

	System	Normal	Abnormal		System	Normal	Abnormal
1	Skin			11	Hernia		
2	Ears			12	Genitalia		
3	Eyes			13	Pelvic (if indicated)		
4	Nose, throat, teeth			14	Rectal		
5	Neck, thyroid			15	Lymphatic		
6	Chest, breasts			16	Extremities		
7	Lungs			17	Neurological		
8	Heart			18	Psychological		
9	Heart murmur			19	Back & spine		
10	Abdomen, liver			20	Joints, shoulders,		
	spleen, kidneys				knees & ankles		

Results of Urinalysis:_____

List any current illness(es), medications and explanations of abnormal findings:_____

_____

_____

_____

Capable of participating in sports? ☐ Yes ☐ No ☐ Collision ☐ Contact ☐ Non-Contact

Signature of Health Care Provider:_____

Printed Name of Health Care Provider_____ Date of Examination_____

IMMUNIZATION RECORD

IV. IMMUNIZATION RECORD

To be completed and signed by your health care provider. ***All information must be in English.***

REQUIRED VACCINES:

A. TETANUS-DIPTHERIA

1. Tdap, one dose required, if it has been 5 years or more since the last dose of Td ..... ___/___/___ (Mo Day Yr)
2. Td within the last ten years ..... ___/___/___ (Mo Day Yr)

B. M.M.R. (Measles, Mumps, Rubella) (two doses required)

Dose 1 given at 12 months after birth or later and Dose 2 given at least 4 weeks after first dose..... **1** ___/___/___ (Mo Day Yr) **2** ___/___/___ (Mo Day Yr)

OR Measles, Mumps, Rubella Titers (clinical history is not acceptable)

MEASLES (Rubeola)

1. Has report of positive immune titer. Specify date..... ___/___/___ (Mo Day Yr)

RUBELLA (German Measles)

2. Has report of positive immune titer. Specify date..... ___/___/___ (Mo Day Yr)

MUMPS

3. Has report of positive immune titer. Specify date..... ___/___/___ (Mo Day Yr)

C. HEPATITIS B (Three(3) doses of vaccine given as a series of three(3) age-appropriate doses (given at 0, 1-2 months after first dose and 6-12 months after first dose) or a positive Hepatitis B surface antibody meets the requirement.)

1. Dose #1 ___/___/___ (Mo Day Yr) Dose #2 ___/___/___ (Mo Day Yr) Dose #3 ___/___/___ (Mo Day Yr)
2. Hepatitis B surface antibody ___/___/___ (Mo Day Yr) ☐ Immune ☐ Non-immune

D. Varicella

1. History of Disease Yes___ No___ OR
2. Birth in U.S. before 1980 (except students in a health program with patient contact) ☐ Yes ☐ No OR
3. Varicella Antibody ___/___/___ (Mo Day Yr) Result: ☐ Immune ☐ Non-immune OR
4. Immunization

a. Dose #1 given at age 12 months or later ___/___/___ (Mo Day Yr) b. Dose #2 given at least at least 4 weeks after first dose ___/___/___ (Mo Day Yr)

ALL FULL-TIME STUDENTS 21 YEARS AND YOUNGER, AND ALL STUDENTS (REGARDLESS OF AGE) LIVING IN A DORMITORY OR OTHER CONGREGATE ON-CAMPUS HOUSING:

E. MENINGOCOCCAL (One dose given at age 16 or older or the enclosed waiver may be signed stating that the student has received information regarding meningococcal disease/vaccination and wishes to decline immunization.)

Vaccinated Date ___/___/___ (Mo Day Yr) Type of Vaccine: ☐ Menommune ☐ Menactra

Recommended Vaccine: a clinical discussion with your health care provider is recommended

Meningitis B (Trumenba) 3 doses: Dose #1 ___/___/___ (Mo Day Yr) Dose #2 ___/___/___ (Mo Day Yr) Dose #3 ___/___/___ (Mo Day Yr)

Meningitis B (Bexsero) 2 doses: Dose #1 ___/___/___ (Mo Day Yr) Does #2 ___/___/___ (Mo Day Yr)

HEALTH CARE PROVIDER

Name: _____ Address: _____

Signature: _____ Phone: _____

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Please turn to the next page for further immunization record information.

V. TUBERCULOSIS SCREENING **See enclosed TUBERCULOSIS RISK QUESTIONNAIRE**

Must be completed by all students and returned with **HEALTH & IMMUNIZATION** form.

HEALTH INSURANCE

Massachusetts Student Plan ☐ Yes ☐ No

Health Insurance Provider, if not Massachusetts State System Plan: **Please attach copy of Health Insurance Card**

MEDICAL TREATMENT RELEASE FOR STUDENTS UNDER 18 YEARS

PARENTAL PERMISSION

In the event that medical treatment is found to be necessary, I hereby authorize the WSU physician or Nurse Practitioner to render medical treatment to my child.

If in treatment of a condition, in the exercise of professional judgment, hospitalization is deemed necessary, I hereby consent to hospital care encompassing routine diagnostic procedure, medical treatment, and surgery which may involve the administration of anesthesia.

_____ _____

Date *Parent or Guardian's Signature*

TUBERCULOSIS RISK QUESTIONNAIRE

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Student Health Services
486 Chandler Street, Worcester, MA 01602

Phone: 508-929-8875
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Must be completed by all students and returned with the **Health & Immunization** form.

Name:_____ Birth Country:_____

Student Signature:_____ Date Completed:_____ Birth Date:____/____/_____

Please circle your answers to the following questions:

1. Have you ever had a positive tuberculosis (TB) test (if yes, please answer question 2 & continue onto Section B): Yes / No
2. Do you have any symptoms of active tuberculosis:
   - Cough greater than 8 weeks Yes / No
   - Cough with bloody sputum Yes / No
   - Unexplained fatigue Yes / No
   - Unexplained weight loss Yes / No
   - Night sweats Yes / No
   - Unexplained fever of 100 degrees F for over 2 weeks Yes / No
3. To the best of your knowledge, have you had close contact with anyone who was sick with TB: Yes / No
4. Were you born in one of the countries listed below: Yes / No
5. Have you ever traveled or lived for more than 1 month in any of the countries listed below: Yes / No
6. Have you ever lived, worked or volunteered in a nursing home, homeless shelter, hospital, or correctional facility: Yes / No

High Risk: If the answer to questions **2, 3, 4, 5, or 6 are "Yes", you are REQUIRED** to have a tuberculin skin test or blood test to check for latent tuberculosis infection. See reverse side of this page for required documentation.

Low Risk: If the answer to all the above were **"No"**, no further testing or further action is required.

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Caho Verde
Cambodia
Cameroon
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cote d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
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
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of?: 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

(To be completed if answered yes to questions 2, 3, 4, 5, or 6)

(To be completed and signed by a healthcare provider)

Student's Name: _____ Birth Date: ___/___/___

Please note: If patient has had a POSITIVE TUBERCULIN SKIN TEST in the past, the test should not be repeated. **Go to Section B** below.

A. TUBERCULIN TESTING (MANTOUX/PPD OR INTEFERON GAMMA RELEASE ASSAY (IGRA))

1.Tuberculin Skin Test—Please note: skin test must be read by a healthcare provider 48 – 72 hours after administration. If no Induration, mark "0".

Date administered: ___/___/___ Mo Day Yr **Date test read:** ___/___/___ Mo Day Yr

Result: _____ mm of induration

Interpretation of Tuberculin Skin Test: (Please use table below and circle response) Negative / Positive

Risk Factor	**Positive Result**
Close contact with a case of TB	5mm or more
Born in a country with a high rate of TB	10 mm or more
Traveled / lived for 1 + months in a country with high TB rates	10 mm or more
No risk factors (test not recommended)	15 mm or more

OR

2. Interferon Gamma Release Assay (IGRA)

Method used: (Please Circle) QFT – G / Tspot Date obtained: ___/___/___ Mo Day Yr

Result: (Please check appropriate response) __ Negative __Positive __Indeterminate/Borderline (requires repeat test)

B. POSITIVE SKIN TEST OR POSITIVE IGRA REQUIRES A CHEST XRAY

1. Date of POSITIVE test: ___/___/___ Mo Day YR **Testing method:** (please circle) Skin test / IGRA

2. Chest X- Ray: (please circle) Normal / Abnormal **Please attach a copy of the report**

3. Treatment: (please circle) Yes / No

Medications, Dates:_____

Healthcare Provider Signature_____ Date ___/___/___