HEALTH SERVICES FORMS INSTRUCTIONS

Anyone living on the Brenau University campus must complete the Health Forms indicated below. These forms must be on file with Health Services prior to the first day of class or prior to living on campus. Please read the instructions, complete the forms, and return them to Brenau University, Office of Admissions, 500 Washington Street SE, Gainesville, GA 30501, or scan and email them to healthservices@brenau.edu.

PERSONAL INFORMATION AND CONSENT FOR SERVICES

Information provided will only be used to provide you with good medical care. It is strictly for use by Health Services and will not be released without your knowledge and written consent.

PHYSICAL EXAMINATION

Must be submitted by anyone living on campus and must be completed by a Physician/Healthcare Provider, NOT a family member.

HEALTH HISTORY

Must be completed by the student.

CERTIFICATE OF IMMUNIZATION

Brenau University's policy is to require certain immunizations for **anyone living on campus**. These requirements include documented proof of immunity to measles, mumps, rubella, varicella (chicken pox), tetanus (within last 10 years), hepatitis B, Meningococcal and TB screening. Please note that dates of immunizations are required and a Healthcare Provider **must** sign the immunization form.

HEALTH SERVICES PERSONAL INFORMATION & CONSENT

This information is strictly confidential and will be used by health Services Staff solely to provide you with good medical care. Information will not be released without your knowledge and written consent.

Personal Information (Please Print in Ink or Type)

Name: _____ Birthday: _____ Age:_____
Last, First Middle Month/Day/Year

Home Address: _____ _____Home Phone: _____
Street City State Zip

Email Address: _____ _____ Cell Phone: _____

If you are under 18 years of age, please provide your parent/guardian information:

Parent/Guardian Name: _____
Last, First Middle

Address: _____ Email Address: _____
Street City State Zip

Telephone #: _____
Home Cell Business

Emergency Contact

Contact Name:_____ Relationship: _____
Last, First Middle

Address: _____ Email Address: _____
Street City State Zip

Telephone #: _____
Home Cell Business

Consent for Diagnostic and Treatment Procedures

All statements on this Health Form are true to the best of my knowledge. I authorize the healthcare providers at Brenau University to perform diagnostic and treatment procedures as may be deemed necessary.

Patient Signature: _____ Date: _____

If patient is under the age of 18 please provide your parent/guardian signature:

Parent/Guardian Signature: _____ _____ Date: _____

Family Educational Rights and Privacy Act of 1974 (FERPA), published by the Department of Health, Education and Welfare requires the patients written approval before parents, guardians, or spouse may be given medical information.

HEALTH SERVICES IMMUNIZATION RECORD

Please complete this form in its entirety or you may send a state certified copy of your immunization record. This form must be submitted by all persons living on campus.

PERSONAL INFORMATION (please print in ink or type) _____

Name: _____ Birthday: _____
Last, First Middle Month/Day/Year

REQUIRED IMMUNIZATIONS (to be completed by Healthcare Provider) _____

_____

MMR (Measles, Mumps, Rubella): Two doses are required for persons born after January 1, 1957
Dose 1 given at age 12 months or later # 1 dose date: ____/____/____
Dose 2 given at least 28 days after first dose # 2 dose date: ____/___/_____

_____

TETANUS-DIPTHERIA (Tdap booster recommended for ages 11-64 unless contraindicated, must be within last 10 years):
Date of most recent booster dose: _____/_____/_____ Type of most recent booster: Td _____ Tdap _____

_____

VARICELLA (chicken pox): Two doses of vaccine or history of disease
Date of 1st dose: ___/__/___ Date of 2nd dose: ____/____/___ or history of disease - Year: _____

_____

HEPATITIS B: Three doses of vaccine for All PERSONS living on campus
#1 dose date: ____/____/_____
#2 dose date: ____/____/_____
#3 dose date: ____/____/_____

_____

MENINGOCOCCAL:
Date of Vaccine: ___/____/_____

TB SCREENING: (Required for students who will be living on campus**)**

1. **Tuberculin Skin Test (TST):** (TST result should be recorded as actual millimeters (mm) or induration, transverse diameter; if no induration, writes "0".

   Date Given: ____/____/_____ Date Read: ____/_____/_____ (**must** be within 48-72 hours)
   mm dd yyyy mm dd yyyy

   Result: _____ mm **Interpretation:** POSITIVE____ NEGATIVE _____ (based on mm of induration as well as risk factors)

2. **Interferon Gamma Release Assay (IGRA)** Date given ___/___/___ (specify method by circling one) QFT-G / QFT-GIT / T-Spot / _____ (OTHER)

3. **Chest x-ray: (Required if TST or IGRA is positive)** Date of chest x-ray: ____/____/____ Result: Normal _____ Abnormal _____

_____

Signature of Healthcare Provider: _____ Date:_____
Address:_____
Phone:_____ Fax:_____

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HEALTH SERVICES HEALTH HISTORY

This form is to be completed by the patient.

PERSONAL INFORMATION (please print in ink or type) _____

Name: _____ Birthday: _____
Last, First Middle Month/Day/Year

HEALTH HISTORY _____

Do you have or have you had any of the following? If yes, please explain.

Acid Reflux	YES NO	Epilepsy/Seizures	YES NO	Paralysis	YES NO
Anemia/Blood Disease	YES NO	Head Injury	YES NO	Physical Limitations	YES NO
Anxiety	YES NO	Hearing Concerns	YES NO	Pneumonia	YES NO
Appetite Loss	YES NO	Heart Disease	YES NO	Psoriasis	YES NO
Arthritis	YES NO	Heart Murmur	YES NO	Seasonal Allergies	YES NO
Asthma	YES NO	Hepatitis	YES NO	Shortness of Breath	YES NO
Back Problems	YES NO	Hernia	YES NO	Sinusitis	YES NO
Bronchitis/Chronic Cough	YES NO	HIV Positive	YES NO	Spinal Disorders	YES NO
Cancer	YES NO	Hypertension	YES NO	Stomach Concerns	YES NO
Chronic Diarrhea	YES NO	Hypoglycemia	YES NO	STDs	YES NO
Chronic Ear Infections	YES NO	Insomnia	YES NO	Strep Throat	YES NO
Colitis, Ulcerative/Spastic	YES NO	Joint Injury	YES NO	Thyroid Concerns	YES NO
Depression	YES NO	Joint Disease	YES NO	Tuberculosis	YES NO
Diabetes	YES NO	Kidney Disease	YES NO	Ulcers	YES NO
Dizziness/Fainting	YES NO	Mental Disorders	YES NO	Unconsciousness	YES NO
Eating Disorders	YES NO	Menstrual Concerns	YES NO	Vision Problems	YES NO
Eczema	YES NO	Mononucleosis	YES NO	Other	YES NO

If you answered yes to any of the previous conditions, please explain: _____
_____
_____

Allergies (list **ALL** medications, food, pollen, environmental, or insect/animal allergies):_____
_____

Are there any other medical conditions or concerns that Brenau University needs to be aware of?
_____
_____
_____

HEALTH SERVICES PHYSICAL EXAMINATION

This form must be completed by your Physician/Healthcare provider.

PATIENT INFORMATION (please print in ink or type) _____

Name: _____ Birthday: _____
Last, First Middle Month/Day/Year

PHYSICIAN / PROVIDER SUMMARY _____

HT _____ WT_____ BP_____

	Normal/Abnormal	Comments
HEENT	▢ / ▢	_____
SKIN	▢ / ▢	_____
HEART	▢ / ▢	_____
LUNGS	▢ / ▢	_____
ABDOMEN	▢ / ▢	_____
MUSCULOSKELETAL	▢ / ▢	_____
NEUROLOGICAL	▢ / ▢	_____

List ALL past or present medical conditions that we need to be aware of:

_____

_____

Are there any conditions (i.e., recent surgery or illness, chronic health problems) that would limit the patient from participating in physical activities? Circle one: YES NO
If you answered YES, please explain:_____

_____

_____

Does the patient take any medication? If so, please list: _____

_____

_____

If the patient is under a current treatment program that you would like to continue, please enclose/attach pertinent medical history and recommendations.

_____

Signature of Healthcare Provider: _____ Date:_____
Please Print: (or use office stamp)
Healthcare Provider Name or Office_____

Address:_____

Phone:_____ Fax:_____