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 moving on campus. Please read the instructions, complete the forms and return them via mail to Brenau University, Health Services, 500 Washington Street SE, Gainesville, GA 30501, or fax to 770-534-6122 or email to healthservices@brenau.edu

PERSONAL INFORMATION, HEALTH HISTORY 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.
Must be completed by the student, available online via this link https://brenau.formstack.com/forms/healthservicesform

PHYSICAL EXAMINATION

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

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.

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

Allergies:_____

PHYSICIAN / PROVIDER SUMMARY _____

HT _____ WT_____ BP_____ Pulse _____ Respirations_____ Pulse Ox._____

	Normal/Abnormal	Comments		Normal/Abnormal	Comments
HEENT	☐ / ☐		ABDOMEN	☐ / ☐	
SKIN	☐ / ☐		MUSCULOSKELETAL	☐ / ☐	
HEART	☐ / ☐		NEUROLOGICAL	☐ / ☐	
LUNGS	☐ / ☐				

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:_____

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:_____