GOODWIN COLLEGE

SHH

Modified: July 13, 2017 2:32 PM

Student Health History

Full Name: ______ Student ID Number: ______

Date of Birth: ______ Semester/Year Beginning at Goodwin: ______

Legal Gender: ______ Preferred Gender Identity: ______

PERMANENT HOME INFORMATION

Permanent Home Address: ______

Preferred Email: ______ Cell Phone: ______ Home Phone: ______

NOTIFY IN CASE OF EMERGENCY

Name: ______ Relationship: ______

Home Phone: ______ Cell Phone: ______

Address: ______

PRIMARY PHYSICIAN/HEALTHCARE PROVIDER

Name: ______ Phone: ______ Fax: ______

Address: ______

MEDICATIONS

List all medications; prescriptions, and over-the-counter medications and supplements that you currently take.

______

ALLERGIES

- ☐ Medication Allergy ______
- ☐ Food Allergy ______
- ☐ Insect Allergy ______
- ☐ X-Ray Contrast ______

Are any of these life-threatening? ☐ YES ☐ NO List if YES: ______

Do you carry an EpiPen? ☐ YES ☐ NO List reason if YES: ______

MEDICAL AND MENTAL HEALTH HISTORY *CHECK ALL THAT APPLY*

- ☐ ADHD
- ☐ Alcohol/drug abuse
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood clotting disorder
- ☐ Cancer
- ☐ Cardiac condition/ heart murmur
- ☐ Crohn's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Immunocompromised
- ☐ Organ Transplant
- ☐ Rheumatoid arthritis
- ☐ Seizure disorder
- ☐ Sickle cell anemia
- ☐ Ulcerative Colitis
- ☐ Other (please list) ______ ______

Explain any of the items that you circled above or if there are any significant medical or mental health conditions for which you seek healthcare. Attach any additional information to further explain your condition or concern.

Prior Hospitalizations, Surgeries, or Orthopedic Procedures - List dates and reasons.

Current Height: ______ Current Weight: ______

SUBMIT ALL COMPLETED FORMS AND ATTACHMENTS BY SCANNING AND EMAILING TO INTERNATIONAL@GOODWIN.EDU

Full Name: Student ID Number:

IMMUNIZATION HISTORY

With the exception of questions 4a-4d, all information pertaining to immunization history must be completed by your healthcare provider.

1. REQUIRED OF ALL STUDENTS BORN AFTER 1956

Measles-Mumps-Rubella (MMR) Vaccination	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY

OR

Measles Single Vaccination	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY
Mumps Single Vaccination	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY
Rubella Single Vaccination	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY

A titer showing immunity to OR incidence of each individual disease is an acceptable alternative to vaccination. Please document below.

Measles Titer Result MM/DD/YYYY ☐ Immune ☐ Not Immune	Measles Disease MM/DD/YYYY
Mumps Titer Result MM/DD/YYYY ☐ Immune ☐ Not Immune	Mumps Disease MM/DD/YYYY
Rubella Titer Result MM/DD/YYYY ☐ Immune ☐ Not Immune	Rubella Disease MM/DD/YYYY

2. REQUIRED OF ALL STUDENTS BORN AFTER 1979

Varicella Vaccination	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY

3. REQUIRED OF ALL STUDENTS LIVING IN GOODWIN HOUSING

Meningitis Vaccination (MCV4) Must cover strains A, C, Y, W-135 (Menactra, Menveo, Mecevax., Nimenrix)	Date: MM/DD/YYYY	Vaccination must have been given within 5 years of your first day of classes.	Exceptions to requirement: ☐ I will not be living on campus-owned housing ☐ I am over 29 years of age

4. REQUIRED OF ALL STUDENTS

TUBERCULOSIS (TB) RISK QUESTIONNAIRE

a. Have you ever had a positive tuberculosis skin or blood test in the past? ☐ YES ☐ NO

If you answered yes, go to "Chest X-Ray/Medication" sections below

b. To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis? ☐ YES ☐ NO

c. Were you born in one of the countries listed on the attached page? ☐ YES ☐ NO

If yes, which country?___________________

d. Have you traveled to or lived for more than one month in one or more of the countries listed? ☐ YES ☐ NO

If yes, which country? ___________________

If you answered NO to all questions, no further action is required.

If you answered YES to any question 4b-4d, you must have a TB blood or skin test. A chest x-ray is not acceptable for 4b-4d.

No exemption for prior BCG. If you have received BCG in the past, a TB blood test is recommended, however, a TB skin test is accepted.

A healthcare provider must document test results below. All testing and Chest X-Ray, if required, must be within 6 months prior to the start of school.

TB BLOOD TEST (IGRA)	TB SKIN TEST (PPD)	CHEST X-RAY	MEDICATION TREATMENT
☐ Quantiferon ☐ T-Spot Date: MM/DD/YYYY Result: ☐ NEG ☐ POS	Date planted: MM/DD/YYYY Date read: MM/DD/YYYY Interpretation: ☐ NEG ☐ POS mm of induration: __________	*Only acceptable/required if past or current positive TB skin or blood test.* *Not required if completed TB treatment.* Chest X-Ray Date: MM/DD/YYYY ☐ NORMAL ☐ ABNORMAL	☐ Latent TB Infection ☐ Active TB Infection Date(s): MM/DD/YYYY Medications:

5. STRONGLY RECOMMENDED VACCINATIONS

Tetanus, Diphtheria, Pertussis (within the last 10 years)	☐ Tdap ☐ Td	Date: MM/DD/YYYY			
Meningococcal Serogroup B	☐ Trumenba (MenB-FHbp) ☐ Bexsero (MenB-4C)		Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY	Dose #3 MM/DD/YYYY
Hepatitis B Vaccination Series	Dose #1 MM/DD/YYYY	Dose #2 MM/DD/YYYY	Dose #3 MM/DD/YYYY	Hep B Surface Antibody Titer MM/DD/YYYY	Result ☐ Immune ☐ Not Immune
Human Papillomavirus	☐ HPV4 ☐ HPV9	Dose#1 MM/DD/YYYY	Dose #2 MM/DD/YYYY	Dose #3 MM/DD/YYYY	

SIGNATURE OF HEALTH CARE PRACTITIONER (MD/DO/APRN/PA)

BY SIGNING BELOW, I AM CERTIFYING THE ACCURACY OF THE INFORMATION DOCUMENTED ON THIS HEALTH HISTORY FORM.

Signature: Date: Phone:

Name (print): NPI#

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LIST OF HIGH RISK TB COUNTRIES FOR QUESTIONANAIRE ON PREVIOUS PAGE

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong
China, Macao
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
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
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 Macedonia
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Taiwan
Tajikistan
Thailand
Timor-Leste
Togo
Tonga
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe