GRADUATE STUDENT HEALTH RECORD FORM

All students are required to file a current health record with Lipscomb University Health Services at the time of enrollment. This information is confidential. ***All sections must be filled out to be considered complete.*** *Please complete both pages and return, by mail or fax,* ***before*** *registration, to:*

Health Center, Lipscomb University,
One University Park Drive, Nashville, TN 37204-3951
Phone: 615.966.6304 Fax: 615.966.5286

Full Name _____ Social Security Number _____

Home Address _____
STREET CITY STATE ZIP

Home Phone _____ Cell Phone _____ E-Mail _____

Date of Birth _____ ❑ Female ❑ Male Citizenship ❑ USA ❑ Other (please specify) _____

Name of Parent / Guardian / Spouse (please circle) _____ Phone _____

Address _____
STREET CITY STATE ZIP

Emergency Contact Name & Number _____ Relationship to Student _____

Semester entering (please state year) Fall _____ Spring _____ Summer _____ Former LU student? ❑ Yes ❑ No Last term attended _____

Program of Study (*this is not the form for Student Pharmacists) _____

MEDICAL HISTORY

❑ Allergy	❑ Dermatology	❑ Hearing/Sight	❑ Anemia	❑ Obesity
❑ High Blood Pressure	❑ Anorexia/Bulimia	❑ Seizure Disorder	❑ Mental Illness	❑ Diabetes
❑ Cardiac/Heart	❑ Gastrointestinal	❑ Immune Disorders	❑ Orthopedic	❑ Thyroid Problem
❑ Genitourinary	❑ Pulmonary/Lung	❑ Headaches/Migraine	❑ Anxiety/Depression	❑ Cancer
❑ Drug/Alcohol Problem	❑ Other _____			

Please **explain** any item marked above (please attach extra sheet if additional space is needed) _____

Please provide allergies or sensitivities ❑ none _____

List any current medications (including regularly taken over-the-counter medications, dietary supplements or herbs) ❑ none _____

IMMUNIZATION REQUIREMENTS

An official shot record must be attached or a health care provider must sign the bottom to verify immunization dates.

Measles, Mumps and Rubella (MMR)

The State of Tennessee requires all students, born after 1956, entering colleges and universities to provide proof of two doses of Measles, Mumps, and Rubella (MMR) vaccine on or after the first birthday and at least 28 days apart. If unable to obtain a record of two MMRs, a blood test (titer) showing proof of immunity of Mumps, Rubeola, and Rubella is acceptable.

Combined Shot (date given): MMR #1 __/__/__ MMR #2 __/__/__ **OR** Titer showing immunity date: __/__/__

Varicella

As of July 2011, the State of Tennessee requires ALL students born after 1979 to have documented date of chickenpox disease **OR** two (2) varicella vaccinations **OR** proof of immunity by positive IgG titer.

Date of disease: __/__/__ **OR** Two (2) Varicella immunizations (date given): #1 __/__/__ #2 __/__/__ **OR** Titer showing immunity date: __/__/__

Health Care Provider Signature: _____ **Date:** _____

(please see other side)

TB ASSESSMENT — HEALTH RECORD FORM

COMPLETE SECTIONS A AND B, OR SECTION C.

A. (circle Yes or No)

Yes No Have you ever been diagnosed with tuberculosis?

Yes No Have you ever had a positive PPD skin test or positive QuantiFeron® TB Gold blood test?

- ▶ If you answered "Yes" to either question, you will need to present a report from your health care provider regarding your chest x-ray which was given in the past six months in the USA.
- ▶ You must also provide a copy of your treatment, including medications and dates.

B. TB EXPOSURE RISK FACTORS (circle Yes or No)

Yes No Foreign-born? Name of country of birth: _____

Yes No Have you volunteered or lived in any of these settings in the past year?

❑ Prison/jail ❑ Long-term Care ❑ Homeless Shelter ❑ Alcohol and Drug Treatment Center ❑ Hospital

Yes No Have you been in close contact with someone who has active TB?

Yes No As a child, were you around an adult who had TB?

Yes No Have you been homeless in the past year?

Yes No Have you ever been an injection drug user?

Yes No Have you traveled or lived in a high-risk country (excludes Canada, Western Europe, Australia, New Zealand and Japan)?

List countries to which you have traveled: _____

_____

OTHER MEDICAL CONDITIONS KNOWN TO INCREASE THE RISK OF TB DISEASE: (circle Yes or No to any that apply)

Yes No Diabetes

Yes No Silicosis

Yes No Leukemia, lymphoma

Yes No Cancer of the neck, head or lung

Yes No Immunosuppressive condition or therapy greater than three weeks (steroids or chemotherapy)

Yes No End-stage kidney disease

Yes No Intestinal bypass or gastrectomy

Yes No Chronic malabsorption syndrome (Crohn's or Ulcerative Colitis)

Yes No Weight loss greater than 10% of your ideal body weight

Yes No HIV/AIDS

Yes No Autoimmune disease

DO YOU HAVE ANY UNEXPLAINED:

❑ Cough ❑ Fever/chills ❑ Loss of appetite ❑ Weight loss ❑ Fatigue ❑ Night sweats

- ▶ If you answer yes to any question in Section B, you must have proof of a PPD skin test or Interferon Gamma Release Assay (IGRA) within the last year. If either is positive, you must follow the directions highlighted in Section A. If all answers are "No," you may skip Section C and sign the bottom.

C. TB SKIN TEST (PPD) (must be within 12 months prior to enrollment)

Date given: __/__/__ Given by (initials): _____ Date read: __/__/__

Results: PPD: mm of induration IGRA: ❑ positive ❑ negative ❑ intermediate

Location of test reading: _____

Reader's Signature _____

I, _____ affirm that the information in Sections A and B is accurate and truthful.
PRINT NAME

Signature _____ Date _____

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