OFFICE USE ONLY

Date Received ________________

	Health Record	
	TB Screening	
	Immunizations	
	Health Insurance	
	Confirmation Sent	
	Athletic Trainer	

HEALTH RECORD

TRINITY UNIVERSITY

CLASSIFICATION

Date Enrolled______________________

	First Year
	Sophomore
	Junior
	Senior
	Graduate
	Transfer

HEALTH HISTORY, PHYSICAL EXAM AND IMMUNIZATIONS REQUIRED FOR ALL STUDENTS LIVING IN RESIDENCE HALLS. PLEASE ANSWER ALL QUESTIONS. INCOMPLETE RECORDS WILL BE RETURNED. TYPE OR PRINT ANSWERS. THE STUDENT SHOULD COMPLETE THE FIRST PAGE. PAGES 2 through 4 SHOULD BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

STUDENT NAME:____ **Trinity ID#**____________________________

Last First Middle

Date of Birth________________ Sex______ Marital status____________ SS#________________________________

Home Address____ Citizenship______________________

City_______________________________ State_______ Zip_________Student's Cell Phone____________________

PARENT OR GUARDIAN____ Relationship__________________________

Street Address____ Home Phone__________________________

City_______________________________ State_______ Zip______________ Work Phone____________________

FAMILY HISTORY

Father: Living____ Deceased_____

Occupation ______________

Mother: Living____ Deceased_____

Occupation ______________

Siblings: #Living____ #Deceased_____

Have any of your relatives had any of the following?

Circle Yes or No Relationship (if yes)

No Arthritis Yes______________________________

No Asthma Yes______________________________

No Heart Disease Yes______________________________

No Cancer Yes______________________________

No Diabetes Yes______________________________

No Kidney Disease Yes______________________________

No Seizure Disorder Yes______________________________

No Emotional Illness Yes______________________________

No Tuberculosis Yes______________________________

No Other: Specify Yes______________________________

PERSONAL MEDICAL HISTORY: Have you ever had or do you have any of the following? Indicate **Yes or No**, please comment on positive answers.

Y or N		Y or N		Y or N		
	Anxiety/Depression		Peptic Ulcer		Scarlet Fever	**Explanation and Dates**
	Asthma		Psychiatric Treatment		German Measles (Rubella)	
	Bleeding Disorder		Recent Weight Change		Measles (Rubeola)	
	Bone Joint Disease		Recurrent Headaches		Mumps	
	Cancer		Seizures/Blackouts		Chicken Pox	
	Chronic Cough		Sexually Transmitted Dis.		Malaria	
	Diabetes		Thyroid Diseases		**ALLERGIES**	
	Eating Disorder		Tuberculosis		Penicillin	
	Female or Menstrual Problem		Wear Contact Lenses		Other Antibiotics	
	Gum/Dental Disorder		Wear Hearing Aid		Sulfa	
	Head Injury		Disabilities		Codeine	
	Heart Disease		Tonsillectomy		Aspirin	
	Hepatitis/Jaundice		Appendectomy		Foods	
	Hi/Lo Blood Pressure		Hernia Repair		Seasonal Pollen	
	Infectious Mononucleosis		Other Operations		Wasp/Bee Stings/Fire Ants	
	Kidney/Bladder Disease		Other Health Problems		Other:	

STATEMENT OF CONSENT FOR TREATMENT & CONFIDENTIALITY

I give consent for the Student Health Services at Trinity University to administer medical and surgical services, including immunizations and allergy injections, and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel.

I understand that all protected health information possessed by the Student Health Service is confidential and will not be disclosed or released without my specific written permission except when used for treatment, payment or other health care operations or as required by law. For more information regarding privacy policies and patient rights contact Health Services.

I also understand that this Consent shall remain in effect the entire time I am a student at Trinity University.

____ ____

Signature of Student Date Signature of Parent if student under age 18 Date

DO NOT RETURN THIS FORM UNTIL ALL PAGES ARE COMPLETE AND SIGNED BY A HEALTH CARE PROVIDER

TO THE EXAMINING PHYSICIAN OR HEALTHCARE PROVIDER: We appreciate your thoroughness in reviewing the patient's medical history and completing **PAGES 2 THROUGH 4** of this form -- performing a physical examination, tuberculosis screening and documenting immunizations.

Date of Examination____/____/____

STUDENT NAME____**Female**_______ **Male**______
LAST FIRST M.I.

Weight__________ **Height**__________ **Blood Pressure**__________ **Pulse** _________

Evaluate the following systems and note abnormalities:

NORMAL (☑)	ABNORMAL FINDINGS (Explain)
________	Head, Ears, Nose or Throat
________	Respiratory
________	Cardiovascular
________	Gastrointestinal
________	Eyes (Refractive)
________	Eyes (Other)
________	Genitourinary
________	Musculoskeletal
________	Metabolic/Endocrine
________	Skin
________	Joint Function

Is student being treated for any medical conditions?

____

____

Is student being treated for any psychological conditions?

____

____

Name and dosage of current medications:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

____
Name of Physician or Healthcare Provider **PRINTED or office stamp**

Street Address ________________________________

City, State, Zip ________________________________

____
Signature of Physician or Healthcare Provider

Phone Number________________________________

CONTINUED ON NEXT PAGE

TUBERCULOSIS SCREENING QUESTIONS REQUIRED TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

STUDENT NAME____
LAST FIRST M.I.

REQUIRED TB SCREENING QUESTIONS [1]

1. **Does the student have signs or symptoms of active TB disease?**

❑ **NO**, Proceed to Question 2.

❑ **YES**, Proceed to Item 3, additional evaluation required to exclude active TB disease (including tuberculin skin testing, chest x-ray and sputum evaluation as indicated).

2. **Was the student born in or recently arrived from a country other than those listed below* or a member of a high-risk group**?**

❑ **NO, STOP**, Further evaluation is not needed.

❑ **YES**, Proceed to Item 3 unless history of previous positive Mantoux test, then proceed to Item 4. Mantoux must be within 6 months of this exam. A history of BCG vaccination should not preclude testing of a member of a high-risk group.

*Categories of high-risk students include those students who have arrived within the past 5 years or were born in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand.

**Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥ 15 mg/d for ≥ 1 month) or other immunosuppressive disorders.

3. **Tuberculin skin test (Mantoux only, 5TU):** Date given: ____/____/____

Date read: ____/____/____ **Result:** __________ **mm**
(Record actual mm of induration, transverse diameter, if no induration write "0")

Interpretation: ❑ positive ❑ negative (based on mm of induration as well as risk factors)

4. **Chest X-ray** (required if tuberculin skin test is positive): Date of chest x-ray: ____/____/____

Result: ❑ normal ❑ abnormal

Does the patient require additional follow up or treatment for Latent TB Infection?____________

VERIFICATION OF SCREENING BY HEALTH CARE PROVIDER

____ ________________________________
Signature of Healthcare Provider Date Printed Name or Office Stamp

1 The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from Centers for Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following website: www.cdc.gov/nchstp/tb/pubs/corecurr/

CONTINUED ON NEXT PAGE

IMMUNIZATIONS REQUIRED FOR TRINITY UNIVERSITY STUDENTS
TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

STUDENT NAME______________________________________ **Date of Birth**____/____/____
LAST FIRST M.I.
TRINITY ID #______________________________

Required vaccines: Texas law requires these vaccinations for students living on campus.

- **POLIO (IPV/OPV)** Date_____/_____/_____

Date required if age 18 or younger

- **TETANUS-DIPHTHERIA (Td)** Date_____/______/______

Must have received within past 10 years

OR **TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)** Date ______/______/_______

- **MEASLES, MUMPS, RUBELLA (MMR)** *(two doses required)*

Dose 1_____/_____/_____ (given at age 12-15 months or later)

Dose 2 _____/_____/_____ *(given at age 4-6 years or later, and at least one month after first dose)*

- **MENINGOCOCCAL TETRAVALENT**

Conjugate (MCV4) (Preferred) Date _____/_____/_____

OR

Polysaccharide vaccine (MPSV4) (alternative if conjugate not available, must be within the last 5 years) Date ___/___/___

Recommended vaccines: Students are encouraged to have these vaccinations but they are not required.

- **HEPATITIS B IMMUNIZATIONS**

Dose 1_____/_____/_____ Dose 2_____/_____/______ Dose 3_____/_____/______

- **HEPATITIS A IMMUNIZATIONS**

Dose 1_____/_____/_____ Dose 2_____/_____/______

- **VARICELLA** (If no history of Chicken Pox or negative Varicella Antibody)

Dose 1 ____/____/_____

Dose 2 ____/____/____ (given at least one month after first dose, if age 13 years or older)

- **Human Papillomavirus Vaccine, HPV Quadrivalent OR Bivalent,** Please circle one

Dose 1 ____/____/____/ Dose 2 ____/____/____ Dose 3 ____/____/____

- **INFLUENZA, annually**

______/______/______ , ______/______/______, ______/______/______, ______/______/______

VERIFICATION OF IMMUNIZATION BY HEALTHCARE PROVIDER

____ ___________ ____
Signature of Healthcare Provider **Date** Printed Name or Office Stamp

When all pages are complete return this form to:

TRINITY UNIVERSITY HEALTH SERVICES
ONE TRINITY PLACE #80
SAN ANTONIO, TEXAS 78212-7200
FAX: (210) 999-8378
PHONE: (210) 999-8111

Office Use Only:
☐ Hold removed
☐ Datatel updated

2009-10 Trinity University Health Insurance Form

All students enrolling for 9 hours or more is required to submit proof of personal health insurance to Health Services or enroll in the Student Health Insurance Plan through the web site at www.ahpcare.com/trinity , select Enroll Online

Name ____ Birth Date ____/____/____
(Please Print) last first middle

Student ID # ______________________ Student SS # ______________________

'09–'10 Class status ☐ FY ☐ SO ☐ JR ☐ SR ☐ GR

OR

☐ Personal 2009-2010 Health Insurance

Check here if you have personal health insurance coverage while enrolled at Trinity University

Attach a copy of the front and back of your insurance card and return this form to Health Services.

☐ Student Health Insurance Plan 2009-2010

Check here if you enrolled in the Student Health Insurance Plan on-line at www.AHPCare.com/trinity. Print the email confirmation of your on-line enrollment and attach a copy to this form.

- ☐ **12 months beginning August 10,2009 through August 9, 2010* ($724)**
- ☐ **Fall semester 2009* ($304)**
- ☐ **Spring semester 2010* ($301)**
- ☐ **Spring and summer semesters 2010* ($488)**

*See 2009-2010 plan brochure available at www.AHPCare.com/trinity for effective and termination dates, schedule of benefits, limitations and exclusions.

Your signature authorizes the release of this information to the Intramural Offices, Athletic Trainer, Fiscal Affairs and the Business Office. The continuing student is required to provide health insurance information yearly and is requested to update this information if it changes during the year. Students requesting the Student Health Insurance Plan must enroll by July 1, 2009 to be billed through Student Accounts. Students registering for fall classes who fail to provide proof of personal health insurance by July 1, 2009 will be enrolled in the Student Health Insurance Policy. If you do not want this insurance a request for cancellation must be submitted to Health Services in writing before August 10, 2009. Proof of personal health insurance (i.e., copy of insurance card, front and back) must accompany this request. No cancellation or refunds of this plan will be made after August 10, 2009.

Signature ________________________________ Date ________________

Attach copy of Personal Health Insurance card (front and back) **OR**
copy of the email confirmation of enrollment in the Student Health Insurance Plan.

Return this form to Health Services with your complete Health Record

Trinity University Health Services
One Trinity Place #80
San Antonio, TX 78212-7200
Phone 210-999-8111 FAX 210-999-8378