Peter J. Fine Student Health Service
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IMMUNIZATIONS: The District of Columbia law requires that all students under the age of 26 at the time of enrollment must be immunized against preventable diseases. It is mandatory that students under the age of 26 receive their immunizations BEFORE arriving on campus. All students regardless of age must complete the written Tuberculosis Risk Assessment (page 2).

Dear Entering Student:

Congratulations on your acceptance. The staff of the Peter J. Fine Student Health Service welcomes you to Gallaudet University. In order to serve you better, it is important to provide Student Health Service will **ALL** of the following information:

Medical History Form: Complete all pages of the health history form in its entirety. Make sure all the required dates and signatures are present. The physical exam form (page 9) is only required if the student is planning on playing sports. The health history form is available online at: Health History Medical Forms for Student Health Service

The complete medical history packet consists of the following forms:

Tuberculosis Risk Assessment Form – p. 2 completed by student

Medical History Form – pages 3, 4, 5, 6, and 7 completed by student

Immunization and Tuberculosis Testing Form – p. 8 only completed by health care provider

Physical Examination Form – p.9 only completed by health care provider

All information regarding Student Health Service can be found online: Website for Gallaudet University Student Health Service.

PLEASE BE ADVISED THAT STUDENT HEALTH SERVICE WILL ONLY ACCEPT MEDICAL RECORDS AND FORMS THAT ARE SCANNED OR FAXED. PHOTOGRAPHS OF MEDICAL RECORDS WILL NOT BE ACCEPTED. THANK YOU

Tuberculosis Risk Assessment Form

The Centers for Disease Control and Prevention and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis. This risk may be as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

Please complete the following form in its entirety. Place a checkmark in the box in front of the section, if any item in the section is true for you. Check the box at the bottom of the page if sections 1-4 do not apply to you. Sign and date the form at the bottom. If you are under 18 years of age, your parent or guardian will need to sign the form.

- ❑ **Section 1: Possible Symptoms of Tuberculosis:**
  - Unexplained weight loss
  - Unexplained elevation of temperature for more than one week
  - Unexplained night sweats
  - Unexplained persistent cough for more than 3 weeks
  - Unexplained cough productive of bloody sputum
- ❑ **Section 2: Risk Factors for Tuberculosis Infection:**
  - Close contact with a known case of active tuberculosis
  - Use of illegal injected drugs
  - HIV (Human Immunodeficiency Virus) Infection
  - Health Care Worker
  - Resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility)
- ❑ **Section 3: Risk Factors for Tuberculosis Disease:**
  - Diabetes mellitus
  - Lymphoma, leukemia or cancer of the head, neck or lung
  - Chronic kidney failure
  - Silicosis
  - Gastrectomy or jejuno-ileal bypass
  - Long-term immunosuppressive therapy
  - Greater than 10% below ideal body weight
  - Previous POSITIVE PPD (TB) test
- ❑ **Section 4:** In the past 5 years, have you lived in or traveled for 30 days or more to any of the following **Areas with a High Prevalence of Tuberculosis** as defined by the World Health Organization and the State Health Department:

  Africa

  Asia/Southeast Asia/Pacific Islands – all countries

  Central & South America – Argentina, Bahamas, Belize, Bolivia, Brazil, Costa Rica, Colombia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela

  Europe – Belarus, Bosnia,-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia

  Middle East – Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

- ❑ **No, none of the items listed in section 1 -4 apply to me.**

Signature of student if over 18 years of age_____

Signature of parent or legal guardian_____

Student's date of birth_____

Date form was signed_____

Gallaudet University Student Health Service Form

Last Name_____First Name_____ Date of Birth _____

Place of birth (city) _____ State_____ Country_____

Street Address_____ City_____ State____ Zip Code _____

Home/Cell #_____Student ID_____ Email _____Circle Male/Female/Transgender

List below Names, addresses, phone #'s of (2) people to be notified in case of an emergency

Name:_____Name:_____

Street Address#_____Street Address#_____

City, State, Zip_____City, State, Zip _____

Home/Cell #_____Home/Cell #_____

Email_____Email_____

Authorization for Medical Treatment: No Medical Treatment will be given if not signed

I certify that the foregoing information is true and complete to the best of my knowledge. I also realize that the information I have given in the medical history section is confidential and for the use of the attending medical staff. I realize that my signature gives the Student Health Service permission to forward my name to the Office for Students with Disabilities, if I have checked "Yes" below.

I give permission to Gallaudet University to provide diagnostic, therapeutic, and operative procedures, voluntary immunizations, and transportation, as may be deemed necessary by its medical staff on my behalf. I am 18 years or older.

Student Signature_____Date_____

Permission for Treatment of Minors

I authorize Gallaudet University Student Health Service to obtain medical information from another medical facility on my behalf for continuity of care

Signature of Parent/Guardian_____Date_____

This consent form is to be signed by the parent or legal guardian of minors (under 18 years of age) so that the appropriate diagnosis and treatment may be promptly carried out without unnecessary delays that may occur with emergency health service procedures. No major health services will be performed except in an emergency, without the permission of the parent or legal guardian being contacted and fully informed. Transportation to area hospitals or diagnostic centers will be the responsibility of the parent or legal guardian

Signature of parent or legal guardian_____Date_____

Insurance Billing Authorization

I hereby given my permission for the Student Health Service to release any and all information related to processing health insurance claims and obtaining payment for medical bills to the appropriate physicians, hospitals, laboratories, insurance agencies, parents/legal guardians, or any other agents as necessary including University personnel

Signature student, parent or legal guardian_____Date_____

The Student Health Service works in cooperation with the Office of Students with Disabilities. May Student Health Service refer your name and medical information regarding your disability to the Office of Students with Disabilities? Yes_____NO____

Gallaudet University Student Health Service (This page to be completed by student)

Student Name_____Student ID#_____

Allergies and Medications

Are you allergic to any of the following? If no, write no. Drugs _____Foods_____

Environmental Agents_____Insects_____

Dust/Pollen_____Are you taking any medications? (If yes, please state dosage and how often you are taking the medication.)_____

Are you receiving allergy shots? Please write Yes or No _____ (Student Health Service is available to administer allergy shots. We request that your healthcare provider give the first dose and then send Student Health Service written detailed instructions for subsequent injections. Student Health Service does not permit allergy shots to be given in residence halls.)

Please circle Yes or No for all the health conditions listed below that you may have or had in the past. **ALL CATEGORIES MUST BE CIRCLED WITH A YES OR NO OR THE FORM WILL NOT BE ACCEPTED**. If you have a serious medical condition for which you see a physician regularly, please enclose a written report of the history and treatment from that physician. AsthmaYes No

Acne YES NO

Anemia Yes No

Back Problems Yes No

Bladder Infection (Cystitis) Yes No

Bleeding Yes No

Sickle Cell Anemia Yes No

Bronchitis Chronic Yes No

Cancer No Yes(location _____)

Cerebral Palsy Yes No

Chickenpox (varicella) Yes No

Chlamydia Yes No

Colitis Yes No

Condyloma (genital warts) Yes No

Deaf or hard of hearing Yes No age of onset _____ Cause of hearing loss_____

Diabetes Yes No

Dizziness Yes No

Dyslexia Yes No

Ear Infections Yes No

Eating Disorders Yes No

Eczema Yes No

Emotional or Mental Illness Yes No

Student Name_____Student ID#_____

Please circle Yes or No for all the health conditions listed below that you may have or had in the past. **ALL CATEGORIES MUST BE CIRCLED WITH A YES OR NO OR THE FORM WILL NOT BE ACCEPTED**. If you have a serious medical condition for which you see a physician regularly, please enclose a written report of the history and treatment from that physician.

Epilepsy or seizures Yes No

Eye Problems Yes No List eye problem_____

Fibrocystic Breast Disease Yes No

Gallbladder Problems Yes No

Gonorrhea Yes No

Gout Yes No

Hay Fever Yes No

Headaches (Migraine or Tension) Yes No

Heart Problems Yes No

Heart Palpitations Yes No

Rheumatic Heart Disease Yes No

Heart Murmur Yes No

Enlarged Heart Yes No

Any other heart conditions No Yes_____

Hepatitis (Type A, B, C) Yes No

High Blood Pressure Yes No

Hypoglycemia (low Blood Sugar) Yes No

Infectious Mononucleosis Yes No

Kidney Infections or Disease Yes No

Measles Yes No

Meningitis/Encephalitis Yes No

Mumps Yes No

Nervous Stomach Yes No

Obesity (greater than 20 lbs overweight) Yes No

Ovarian Cyst Yes No

Pelvic Infection Yes No

Phlebitis Yes No

Pneumonia Yes No

Rheumatic Fever Yes no

Rheumatoid Arthritis Yes No

Rubella (German Measles) Yes No

Student Name_____Student ID#_____

Please circle Yes or No for all the health conditions listed below that you may have or had in the past. **ALL CATEGORIES MUST BE CIRCLED WITH A YES OR NO OR THE FORM WILL NOT BE ACCEPTED**. If you have a serious medical condition for which you see a physician regularly, please enclose a written report of the history and treatment from that physician.

Sinus Problem (Chronic) Yes No

Syphilis Yes No

Thyroid Problem Yes No

Have you received treatment or counseling for emotional problems? Yes No

Have you ever tried to commit suicide? Yes No

Do you vomit, use laxatives, or fluid pills to lose weight? Yes No

Do you feel like you can control all the demands in your life on a daily basis? Yes No

Do you usually feel sad, tired, and depressed? Yes No

Do you lose your temper often? Yes No

Are you disturbed about family situations? Yes No

Do you have problems sleeping? Yes No

How many times do you drink alcohol per week? (0-1) (2-3) (3-7)

Approximate number of drinks per occasion? (0-2) (3-4) (5-10)

At what age did you start drinking alcoholic beverages?_____

Do you smoke? (cigarettes, pipe, cigars) Yes No

How many packs per day do you smoke?____

Do you chew tobacco/snuff? Yes No

How long have you smoked or used tobacco products YES NO

Medical Conditions	**Father**	**Mother**	**Brother/Sister**	**Children**	**Grandparents**
Deaf or Hard of Hearing					
Alcoholism					
Allergies/Asthma					
Anemia					
Bleeding Disorders					
Cholesterol Problems					
Cancer					
Diabetes					
Epilepsy					
Glaucoma/Other Vision Problems					
Heart Problems					
High Blood Pressure					
Kidney/Bladder					
Nervous Breakdown					
Stroke					
Stomach Ulcer or Other Problems					
Tuberculosis					
Arthritis					

Student Name_____Student ID#_____

Immunizations

Students under the age of 26 are required by the District of Columbia Immunization Law 3-20 to provide documentation of immunity from Diphtheria, Tetanus, Hepatitis B, Measles, Mumps, Rubella, Varicella, and Meningitis. Students under the age of 18 must also be vaccinated against Polio.

All students are required to submit the Tuberculosis Risk Assessment Screening form regardless of age. If the student poses any risk factors for tuberculosis, additional testing will be required at the discretion of Student Health Service. All Tuberculosis testing results must be within the last 12 months prior to attending class.

COPIES OF YOUR IMMUNIZATION RECORD SIGNED BY A HEALTH CARE PROVIDER WILL ALSO BE ACCEPTED

Immuunizations	Original Series month/Day/Year	Booster month/day/year	Booster Month/day/year	Booster Month/day/year
Tetanus/Diphtheria or Tdap				
Measles, Mumps, Rubella (2 vaccines are required				
Polio – (under the age of 18)				
Varicella – (2 vaccines are required)				
Hepatitis B series required				
Hepatitis A				
Menactra (meningitis)				
Meningitis B				

Tuberculosis Screening (PPD)

Tuberculosis Screening	Date PPD Planted	Dated PPD Read	Results of PPD	Date PPD Planted	Dated PPD Read	Results of PPD
Mantoux (PPD)						

Tuberculosis Testing

Tests	Date	Results
Chest X-Ray		
Quantiferon Gold		

The following information must be completed and signed by a health care provider. Thank you

Date_____

Printed name of provider_____Signature of provider_____

Address of facility_____

Phone number of provider_____ Fax#_____