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____
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. 

Asthma Yes 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
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
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

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

<table>
<thead>
<tr>
<th>Immunizations</th>
<th>Original Series</th>
<th>Booster</th>
<th>Booster</th>
<th>Booster</th>
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<tr>
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<td>month/Day/Year</td>
<td>month/day/year</td>
<td>Month/day/year</td>
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<tr>
<td>Tetanus/Diphtheria or Tdap</td>
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<tr>
<td>Measles, Mumps, Rubella (2 vaccines are required)</td>
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<tr>
<td>Polio – (under the age of 18)</td>
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<td>Varicella – (2 vaccines are required)</td>
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<tr>
<td>Hepatitis B series required</td>
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<tr>
<td>Hepatitis A</td>
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<tr>
<td>Menactra (meningitis)</td>
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<tr>
<td>Meningitis B</td>
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**Tuberculosis Screening (PPD)**

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<th>Tuberculosis Screening</th>
<th>Date PPD Planted</th>
<th>Dated PPD Read</th>
<th>Results of PPD</th>
<th>Date PPD Planted</th>
<th>Dated PPD Read</th>
<th>Results of PPD</th>
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<tbody>
<tr>
<td>Mantoux (PPD)</td>
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**Tuberculosis Testing**

<table>
<thead>
<tr>
<th>Tests</th>
<th>Date</th>
<th>Results</th>
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<tbody>
<tr>
<td>Chest X-Ray</td>
<td></td>
<td></td>
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<tr>
<td>Quantiferon Gold</td>
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</tbody>
</table>

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#________________________