



HEALTH SERVICES
Student Affairs

SETON HALL UNIVERSITY

Accredited by the
ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

HEALTH FORM

Seton Hall University Health Services
400 South Orange Avenue, South Orange, New Jersey 07079
Phone (973) 761-9175 • Fax (973) 761-9193
Website: <http://www.shu.edu/offices/health-services/>

Due date:
Fall Semester: August 1
Spring Semester: December 15

Name _____ SHU ID# _____
last first middle

Home Address _____
number and street city state zip

Telephone (____) _____ Date of Birth _____ Male__Female__ Place of Birth _____ (country)

Semester Entering Seton Hall University _____

EMERGENCY CONTACT: (Name, Relationship and Phone number)

PARENT/GUARDIAN CONSENT: (Complete only if student is minor)

The law requires that parental permission be obtained for medical evaluation/treatment for minors. The following consent should be signed by parent/guardian so that care can be provided.

I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/ daughter/ward.

Student's Name _____

Parent/Guardian Signature _____ Date _____

Relationship _____

PLEASE CHECK: RESIDENT COMMUTER ONLINE

PLEASE CHECK: UNDERGRADUATE GRADUATE LAW

HEALTH INSURANCE INFORMATION

STUDENTS WHO HAVE THEIR OWN INSURANCE:

- 1) Attach a front/back copy of your card to this form. Carry a copy of your card.
- 2) Complete the online waiver for exemption from student health insurance (deadlines apply).

STUDENTS ENROLLING IN THE STUDENT HEALTH INSURANCE PLAN:

- 1) Please refer to website for plan details.
- 2) Coverage effective August 15. Cards will be issued after classes begin.

MEDICAL HISTORY

FAMILY HISTORY

All medical information is strictly confidential.

Age if living, or cause of death: _____

Father _____ Mother _____ Siblings _____

Check the following diseases that have appeared among **parents and siblings**:

| CONDITION | YES | NO | WHO | CONDITION | YES | NO | WHO |
|----------------------------|-----|----|-----|---------------------------------|-----|----|-----|
| High blood pressure | | | | Asthma | | | |
| Heart disease | | | | Tuberculosis | | | |
| Stroke | | | | Psychological/emotional illness | | | |
| Sudden death before age 50 | | | | Alcohol/addiction issues | | | |
| Diabetes | | | | Other: | | | |
| Cancer | | | | Other: | | | |

PERSONAL HISTORY

Do you have allergies to medications? Yes ___ No ___ If "yes," please list: _____

Do you have any allergies to latex, food, insects or other allergen? Yes ___ No _____

Height: _____ Weight: _____

(If you answer YES to any of the following questions, please provide details in space provided below.)

| | | | | | |
|---|---|---|---|---|---|
| High blood pressure? | Y | N | Have you ever been hospitalized? | Y | N |
| Heart murmur or any disorder of the heart? | Y | N | Have you ever had an operation? | Y | N |
| Asthma? | Y | N | Do you have a disability (physical or learning)? | Y | N |
| Hay fever, hives, seasonal allergies? | Y | N | Do you have a history of an eating disorder? | Y | N |
| Diabetes? | Y | N | Do you have emotional health problems requiring therapy or medications? | Y | N |
| Thyroid or endocrine disorder? | Y | N | Do you smoke? | Y | N |
| Reflux, ulcers, colitis or irritable bowel? | Y | N | Do you have a past/present history of substance abuse? | Y | N |
| Kidney stones or history of kidney disease? | Y | N | Do you have a past/present history of alcohol abuse? | Y | N |
| Hepatitis? | Y | N | Do you have a past/present history of gambling? | Y | N |
| Cancer? | Y | N | List other conditions as needed: | | |
| Migraine headaches? | Y | N | | | |
| Seizure disorder? | Y | N | | | |
| Head injury/concussion? | Y | N | | | |
| Shingles (herpes zoster)? | Y | N | | | |

Remarks _____

Please list any medications you use on a regular basis. (Include prescription, over-the-counter, vitamins and supplements.)

TUBERCULOSIS RISK QUESTIONNAIRE:

(Student completes)

| | YES | NO |
|---|-----|----|
| Have you ever had a positive reaction to a tuberculosis (PPD) skin test? | | |
| Were you born in one of the countries listed below? | | |
| Within the past five years have spent three or more months in one of the countries listed below? | | |
| Do you have a productive, prolonged cough that has lasted more than three weeks with chest pain, bloody sputum, fever, chills, night sweats, appetite loss, weight loss or tiredness? | | |
| Do you have HIV or other disease that weakens your immune system? | | |
| Have you recently taken immunosuppressive drugs or prednisone (at least 15mg/day for one month)? | | |
| Are you an employee, volunteer or resident of a high risk setting (hospital, health care setting, nursing home, correctional facility or homeless shelter)? | | |
| Do you have a history of illicit drug use? | | |

HIGH PREVALENCE COUNTRIES (WORLD HEALTH ORGANIZATION 2009)

| | | | | | | |
|----------------------------------|------------------------------|---------------|----------------------------------|---------------------|---|------------------------------------|
| Afghanistan | Cameroon | Eritria | Kuwait | Morocco | St. Vincent & the Grenadines | Timor-Leste |
| Algeria | Cape Verde | Estonia | Kyrgyzstan | Mozambique | Sao Tome & Principe | Togo |
| Angola | Central African Rep. | Ethiopia | Lao People's Democratic Republic | Myanmar | Senegal | Tonga |
| Argentina | Chad | Fr. Polynesia | Latvia | Namibia | Serbia | Trinidad and Tobago |
| Armenia | China | Gabon | Lesotho | Nepal | Sierra Leone | Turkey |
| Azerbaijan | Colombia | Gambia | Liberia | Nicaragua | Singapore | Turkmenistan |
| Bahrain | Comoros | Georgia | Libyan Arab Jamahiriya | Niger | Solomon Islands | Tuvalu |
| Bangladesh | Congo | Ghana | Lithuania | Nigeria | Somalia | Uganda |
| Belarus | Cook Islands | Guam | Madagascar | Pakistan | South Africa | Ukraine |
| Belize | Cote d'Ivoire | Guatemala | Malawi | Palau | Sri Lanka | United Republic of Tanzania |
| Benin | Croatia | Guinea | Malaysia | Panama | Sudan | Uruguay |
| Bhutan | Democratic Republic of Korea | Guinea-Bissau | Maldives | Papua New Guinea | Suriname | Uzbekistan |
| Bolivia (Plurinational State of) | Democratic Republic of Korea | Guyana | Mali | Paraguay | Swaziland | Vanuatu |
| Bosnia & Herzegovina | Democratic Republic of Congo | Haiti | Marshall Islands | Peru | Syrian Arab Republic | Venezuela (Bolivarian Republic of) |
| Botswana | Djibouti | Honduras | Mauritania | Philippines | Tajikistan | Viet Nam |
| Brazil | Dominican Rep | India | Mauritius | Poland | Thailand | Yemen |
| Brunei- | Ecuador | Indonesia | Micronesia (Federated States of) | Portugal | The former Yugoslav Republic of Macedonia | Zambia |
| Darussalam | El Salvador | Iraq | Mongolia | Qatar | | Zimbabwe |
| Bulgaria | Equatorial-Guinea | Japan | Montenegro | Republic of Korea | | |
| Burkina Faso | | Kazakhstan | | Republic of Moldova | | |
| Burundi | | Kenya | | Romania | | |
| Cambodia | | Kiribati | | Russian Federation | | |
| | | | | Rwanda | | |

HEALTH CARE PROVIDER INTERPRETATION GUIDELINE:

| | | |
|--|---|---|
| >5mm is positive: -HIV infected persons -a recent contact with TB disease -persons with fibrotic changes on chest x-ray consistent with prior TB -organ transplant recipient -immunosuppressed patients taking >15mg/day of Prednisone for >one month, taking TNF a-antagonist or other immunosuppressive medications | >10 mm is positive: -persons born in high prevalence country or who resided in one for 3 or more months -history of illicit drug use -mycobacteriology laboratory personnel -history of resident, worker, or volunteer in high-risk congregate settings -persons with the following conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes | >15 mm is positive: -persons with no known risk factors for TB disease |
|--|---|---|

THIS SECTION MUST BE COMPLETED BY HEALTH CARE PROVIDER

Patient Name _____ Date of Birth _____

If you answered yes to any of the questions on the tuberculosis risk questionnaire on previous page, your health care provider must complete this box.

TUBERCULOSIS (PPD) SCREENING: Must be administered **within 6 months** before the first day of class.

Date given: _____ Date read: _____ (Must be 48-72 hours after test) Reaction: _____ mm
 Result: Positive (please see interpretation guidelines) Negative
Positive tests require a chest x-ray (attach radiologist report) Date of x-ray: _____ Result: Normal Abnormal
 Treatment for LTBI? Yes No Medications used: _____ Dates of treatment: _____
 Date treatment declined _____

IMMUNIZATION RECORD

REQUIRED:

MEASLES, MUMPS AND RUBELLA: Provide documentation of two doses of vaccine or laboratory proof of immunity.

OR \longleftrightarrow **M.M.R. (Measles, Mumps, Rubella combined)**

1. Born before 1957 and therefore considered immune.

2. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ / ____ / ____

3. Dose 2 - Immunized at least one month after Dose 1 _____ / ____ / ____

MEASLES

1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ / ____ / ____

2. Dose 2 - Immunized at least one month after Dose 1 _____ / ____ / ____

RUBELLA

1. Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ / ____ / ____

2. Immunized at least one month after Dose 1 _____ / ____ / ____

MUMPS

1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ / ____ / ____

2. Dose 2 - Immunized at least one month after Dose 1 _____ / ____ / ____

HEPATITIS B SERIES (If enrolled for 12 or more credits)

(#1) _____ / ____ / ____ (#2) _____ / ____ / ____ (#3) _____ / ____ / ____

MENINGITIS (Required for incoming students living on campus. Dose must be within five years of enrollment.)

Check one: Menactra Menomune Menveo _____ / ____ / ____ Booster _____ / ____ / ____

TETANUS (Booster within the past ten years): Td _____ / ____ / ____ **OR** Tdap _____ / ____ / ____

RECOMMENDED BUT NOT REQUIRED:

POLIO (Completed primary series of polio immunization): YES NO

VARICELLA (CHICKEN POX): Dose #1 _____ / ____ / ____ Dose #2 _____ / ____ / ____

HEALTH CARE PROVIDER (please print)

Name/Title _____

Address _____

Signature _____ Date _____ Phone (_____) _____

Provider Stamp Required

