New Student (Non-Athlete) Health Form 2022-2023

1. **IMPORTANT: This form is for <u>non-athletes ONLY</u>.** (For athletes: Do not use this form. After June 1, athletes will receive an email from Benedictine Athletic Training with instructions and a link to complete health forms online. Please complete the forms online by August 1. Bring a copy of your immunization record with you on your move-in day.)
2. **For all other new students:** Download and complete this form by August 1. Scan and email it to jadrian@benedictine.edu or mail it to: Janet Adrian, RN, BSN | 1020 N. 2nd Street | Atchison, KS 66002. It is recommended, but not required, to scan the front and back of your insurance card and send it along with this form.

Part I: Student Information

Student First: _____ Student Last: _____ Student Middle: _____

Sex (CIRCLE): M F Date of Birth: ___/___/___ Age: _____

Academic Year (CIRCLE): 1 2 3 4 5

Student Email: _____ Student Cell #: _____

Student Home Address (City, State, Zip): _____

Father's Name: _____ Father's Phone: _____

Mother's Name: _____ Mother's Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone #: _____

Part 2: Medical History

Do you have a present or past history of: (check all that apply)

Rubella	☐	Chickenpox	☐	Thyroid Disease	☐
Rebeola	☐	Mononucleosis	☐	Meningitis	☐
Hepatitis	☐	Mumps	☐	HIV	☐
Alcohol Abuse	☐	Anemia	☐	Arthritis	☐
Asthma	☐	Back Problems	☐	Cancer	☐
Colitis	☐	Convulsions/Seizures	☐	Cough (chronic)	☐
Depression	☐	Diabetes	☐	Disability/Handicap	☐
Drug Abuse	☐	Ear Trouble/Hearing Loss	☐	Eating Disorder	☐
Eye Disease/Problems	☐	Gallbladder Trouble	☐	Hay Fever (recurrent)	☐
Head Injury	☐	Headache (recurrent)	☐	Heart Disease/Problems	☐
Hepatitis/Jaundice	☐	Hernia/Rupture	☐	High Blood Pressure	☐
Intestinal/Stomach Trouble	☐	Joint Disease/Injury	☐	Measles	☐
Menstrual Problems	☐	Migraine Headaches	☐	Pneumonia	☐
Paralysis	☐	Polio	☐	Psychological Counseling	☐
Rheumatic Fever	☐	Scarlet Fever	☐	Sexually Transmitted Disease	☐

Sickle Cell Trait/Anemia	☐	Sinus Trouble	☐	Skin Problems (chronic)	☐
Sleep Problems	☐	Smoking (how long?)	☐	Spleen, surgical removal	☐
Thyroid Disease	☐	Tuberculosis	☐	Urinary Tract Infection	☐
Other	☐	_____			

If you checked any of the above, please explain briefly:

_____

_____

_____

Special health concerns:

_____

_____

_____

Hospitalization / Surgical history:

_____

_____

_____

Current Medications	Condition	Dosage	Date(s)

Drug allergies:

_____

_____

_____

Allergies (latex, food, seasonal, etc.):

_____

_____

_____

Part 3: Family Medical History – *Please provide relationship in space provided.*

Alcohol/Drug Abuse	_____	Cancer (type)	_____	Death Before Age 50	_____
Diabetes	_____	High Cholesterol	_____	Heart Disease	_____
Hypertension/Stroke	_____	Mental Illness	_____	HIV	_____

Part 4: Consent for Treatment

By signature, I verify that the information provided on this form is accurate and complete and truthfully recorded. I authorize Benedictine Student Health Center to provide medical services, immunizations, and therapeutic services to the above-named student as may be necessary, and if needed, to refer to private care when special service is indicated. (Parent must also sign if student is under 18 years of age.)

Student Signature: _____ Parent Signature: _____

Date: _____ Date: _____

Part 5: Required Immunizations and Tuberculosis Screening

The Benedictine College policy REQUIRES that all newly admitted or readmitted students born after January 1,1957 show proof of TWO vaccinations for Measles, Mumps, Rubella; show proof of Meningitis vaccine; complete the tuberculosis screening stated below; show proof of Tetanus/Diphtheria vaccine; and show proof of Tetanus/Diphtheria booster. Failure to do so will result in being placed on administrative hold (i.e. you will be blocked from enrolling in future classes). History of Measles is NOT acceptable. Please submit one of the following:

- This personal record completed by a healthcare giver
- OR a physician or clinic report
- OR a copy of your school immunization record

A. REQUIRED MMR (Measles, Mumps, Rubella)

Date: 1st ____/____/____ Date: 2nd ____/____/____
Or: Measles 1st ____/____/____ Date: 2nd ____/____/____ Or date of Immune Titer: ____/____/____
And Mumps ____/____/____ Or date disease confirmed by physician: ____/____/____ Or date of Immune Titer: ____/____/____
And Rubella ____/____/____ Or date of Immune Titer: ____/____/____ (clinical history NOT acceptable for Rubella)

B. REQUIRED Tuberculosis Screening (All students must answer the following by writing YES or NO.)

____ You are from or have lived for 2 months or more in Africa, Mexico, Central or South America, the Caribbean, Oceania/Pacific Islands, Asia, Indian Subcontinent, Middle East, or Eastern Europe & N.I.S. (circle those that apply)
____ You have had any of the following symptoms for more than 2 weeks: persistent cough, bloody sputum, night sweats, fever, weight loss, or loss of appetite. (circle those that apply)
____ You have been diagnosed with a chronic medical condition that may impair your immune system.
____ You have had a recent known exposure to Tuberculosis.
____ You are a healthcare worker.
____ You are a volunteer or employee in a nursing home, prison, or other residential institution.

If you answered YES to any of the above, the following is required:

- **Screening:** Come to the Student Health Center for a free Tuberculosis skin test during business hours (call 913-360-7117 for busiess hours) after arrival to campus.
  OR provide documentation of PPD Mantoux skin tests done in the U.S. within the past 12 months:
  Date given: ____/____/____ Date read: ____/____/____ Result in m.m. of induration: _____
  (International students - provide date given if BCG given: ____/____/____)
- **Chest X-Ray:** Chest x-rays will be required for anyone with a positive skin test. X-rays will be taken at Amberwell Health. Or you may submit an x-ray report taken within the last 12 months, if history of positive PPD.
  Date of positive PPD: ____/____/____
- **Treatment**: A student with a positive skin test will be referred for follow up for possible treatment. If you have been treated for TB infection or disease, please provide documentation.

C. REQUIRED MENINGITIS VACCINE Date: ____/____/____

D. REQUIRED TETANUS/DIPHTHERIA: Completed primary series of tetanus/diphtheria immunizations (DtaP or DTP)
Date: 1st ____/____/____ Date: 2nd ____/____/____ Date: 3rd ____/____/____ Date: 4th ____/____/____ Date: 5th ____/____/____

E. REQUIRED TETANUS/DIPHTHERIA BOOSTER within the last 10 years ____/____/____

Part 6: Highly Recommended Immunizations

Hepatitis B Date: 1st ____/____/____ Date: 2nd ____/____/____ Date: 3rd ____/____/____
Varicella (if not immune to Chicken Pox) Date: 1st ____/____/____ Date: 2nd ____/____/____
Or date of Immune Titer: ____/____/____
Influenza (available at Student Health Center) ____/____/____ ____/____/____ ____/____/____ ____/____/____
Other:_____ Date: ____/____/____

Medical Provider – Must be one of the following: ☐ MD ☐ Physician's Assistant ☐ Nurse Practitioner

Signature: _____ Print Name: _____

Date: _____ Telephone Number: _____

Address (City, State, Zip): _____

Part 7: Statement of Exemption to Immunization Law

If your personal or religious beliefs or specific medical condition preclude inoculation, you must sign one of the following waivers. Pregnancy is justification for temporary medical exemption. Are you pregnant? _____ In the event of an outbreak, exempted persons will be subject to quarantine and exclusion from school. No reimbursement of tuition will be provided.

Medical Exemption: The physical condition of the above-named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions.

Signature: _____ Print Name: _____

Date: _____ Telephone Number: _____

Religious/Personal Exemption: Parent or guardian of the above-named student or the student himself/herself adheres to a religious or personal belief opposed to immunizations. (Parent must also sign if student is under 18 years old.)

Student Signature: _____ Parent Signature: _____

Date: _____ Date: _____