



**POST UNIVERSITY**  
 Student Health Services  
 800 Country Club Road, P.O. Box 2540  
 Waterbury, CT 06723-2540  
 (203) 596-4503  
 Fax (203) 841-1179

PERSONAL AND  
 CONFIDENTIAL

## STUDENT HEALTH FORM

### PART I: TO BE COMPLETED BY STUDENT

**Entering semester:** Fall \_\_\_ Spring \_\_\_ Year \_\_\_ **Status:** Resident \_\_\_ Commuter \_\_\_ **Gender:** Male \_\_\_ Female \_\_\_

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Home phone number (\_\_\_\_) \_\_\_\_\_ Cell phone number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Country of birth: \_\_\_\_\_

**In case of an emergency notify:**

1. Full name: \_\_\_\_\_ Relationship \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

2. Full name: \_\_\_\_\_ Relationship \_\_\_\_\_

Cell phone: \_\_\_\_\_ Home phone: \_\_\_\_\_ Business phone: \_\_\_\_\_

### STUDENT AUTHORIZATION FOR TREATMENT

I hereby authorize the Post University Health Services to provide medical treatment and services they deem appropriate (to include outside providers for medical treatment, physical exams, and immunizations).  
 This authorization will remain in effect as long as I am a student at Post University.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PARENT / GUARDIAN'S SIGNATURE (FOR STUDENTS UNDER 18 YEARS OLD):** \_\_\_\_\_ Date: \_\_\_\_\_

### HEALTH INSURANCE IS MANDATORY FOR ALL FULL-TIME STUDENTS

All full-time students will be billed automatically for the University insurance plan unless a student provides the necessary information through the on-line waiver found at [www.gallagherstudent.com/Post](http://www.gallagherstudent.com/Post) by the first day of classes. Please contact the University's insurance provider with any questions pertaining to the insurance coverage or the waiver at **(800) 321-4449**. To ease the Health Services office in providing you with treatment or in the event of a medical emergency, please attach a copy of the front and back of the insurance card here:

**FRONT**

**BACK**

**PART II: TO BE COMPLETED BY THE STUDENT**

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**MEDICAL HISTORY OF THE STUDENT**

If you have had any of the following disorders and / or diseases, please indicate at what age on the line provided:

**HEAD / NERVOUS SYSTEM**

- Headaches, recurrent
- Migraine
- Concussion
- Severe head injury
- Seizures / Convulsions
- Dizzy spells / fainting
- Insomnia
- Recurrent anxiety
- Excessive nervousness
- Recurrent depression
- Neuromuscular disorder

**DENTAL**

- Poor teeth / toothaches
- Gum disease

**INFECTIOUS DISEASE**

- Mononucleosis
- Chicken pox
- Rheumatic fever
- TB or positive skin test
- Malaria
- Measles (Rubella)
- Meningitis
- Sexually transmitted disease
- German Measles (Rubella)
- Mumps

**NECK**

- Swollen glands, frequent
- Thyroid problem / disease

**HEART / LUNGS**

- High cholesterol
- High blood pressure
- Heart murmur
- Palpitations
- Shortness of breath
- Chest pain
- Asthma/wheezing
- Chronic cough
- Pneumonia
- Pleurisy
- Bronchitis
- Do you smoke?

**ALLERGY**

- Hay fever
- Food allergy
- Medicine allergy
- Hives

**PAST HISTORY**

- Operations
- Serious injury / accident
- Emotional problem
- Serious illness

**BLOOD**

- Anemia
- Easy bruising
- Sickle cell anemia/trait

**URINARY**

- Frequent urination
- Painful urination
- Blood in the urine
- Recurrent urinary infection
- Kidney infection
- Kidney stone

**DIGESTIVE**

- Ulcers
- Chronic abdominal pain
- Diarrhea, chronic/recurrent
- Colitis / Ileitis
- Irritable bowel syndrome
- Gallstones
- Hepatitis / jaundice
- Appendectomy
- Hemorrhoid

**OTHER**

- Diabetes
- Malignant disease/cancer
- Anorexia nervosa
- Bulimia

**EYES / EAR / NOSE / THROAT**

- Wear glasses / contacts
- Blindness
- Color blindness
- Eye injury / disease
- Deafness / hearing aid
- Perforated ear drum
- Repeated ear infections
- Repeated nose bleeds
- Frequent sore throats
- Tonsil/adenoid removed
- Sinus infections

**BONES / JOINTS**

- Fractures / dislocations
- Painful joints
- Knee problems
- Paralysis / polio
- Back problems

**SKIN**

- Acne
- Other skin disease

**OTHER HEALTH**

**PROBLEMS:** \_\_\_\_\_

**MEDICATIONS:** \_\_\_\_\_

Please note any illnesses or conditions for which you now are under treatment: \_\_\_\_\_

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Please give a brief explanation and approximate date for each illness / condition (you indicated above) that you have had:

I certify to the best of my knowledge that the information on this form is complete and correct.

Students signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / guardian's signature if under 18 years old: \_\_\_\_\_ Date: \_\_\_\_\_

**PART III: TO BE COMPLETED BY A HEALTH CARE PROVIDER**

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**EXAMINATION**

Weight \_\_\_\_\_ Height \_\_\_\_\_ Blood pressure \_\_\_\_\_

Vision without glasses \_\_\_\_\_ Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Hearing: Right \_\_\_\_\_

Vision with glasses \_\_\_\_\_ Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ Hearing: Left \_\_\_\_\_

| SYSTEM                               | NORMAL | DESCRIBE IF ABNORMAL | REQUIRED    |
|--------------------------------------|--------|----------------------|-------------|
| Skin                                 |        |                      | Date:       |
| Ears                                 |        |                      | Urinalysis: |
| Eyes                                 |        |                      | Sp. Gr.     |
| Nose, throat                         |        |                      | Sugar       |
| Teeth, gingiva                       |        |                      | Protein     |
| Neck, thyroid                        |        |                      | Micro       |
| Chest, breasts                       |        |                      | Date        |
| Lungs                                |        |                      | Hgb/hct     |
| Heart (describe murmur, click, etc.) |        |                      |             |
| Abdomen, liver, spleen, kidneys      |        |                      |             |
| Hernia                               |        |                      |             |
| Genitalia                            |        |                      |             |
| Pelvic (if indicated)                |        |                      |             |
| Rectal, Pilonidal                    |        |                      |             |
| Extremities, back, spine             |        |                      |             |
| Lymphatic                            |        |                      |             |
| Neurological                         |        |                      |             |
| Psychological                        |        |                      |             |

1. List all **ALLERGIES** (including medications, insect, etc.) \_\_\_\_\_

Type of reaction (ie: rash, urticarial, anaphylaxis) \_\_\_\_\_

2. List all **MEDICATIONS** currently being taken: \_\_\_\_\_

3. Student's physical restrictions: Unrestricted \_\_\_\_\_ Partial restriction \_\_\_\_\_ Full restriction \_\_\_\_\_

Comment: \_\_\_\_\_

4. Status of student's health: Excellent \_\_\_\_\_ Good \_\_\_\_\_ Poor \_\_\_\_\_

Comment: \_\_\_\_\_

5. This student is physically qualified to participate in intercollegiate sports: Yes \_\_\_\_\_ No \_\_\_\_\_

Health Care Provider Print Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address (Street, city, zip): \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_ Date of Examination: \_\_\_\_\_

## Immunizations

(To be completed by a Health Care Provider)

1. **MMR** (Measles, Mumps, Rubella) – 2 Vaccine dates required by CT law required for all students born after 1/1/1957.

#1 \_\_\_\_\_ (given on or after 1<sup>st</sup> Bday)

#2 \_\_\_\_\_ (at least 28 days after the first)

**(Laboratory report must be attached for all titers showing immunity)**

Measles antibody titer results \_\_\_\_\_ Date \_\_\_\_\_

Rubella antibody titer results \_\_\_\_\_ Date \_\_\_\_\_

Mumps antibody titer results \_\_\_\_\_ Date \_\_\_\_\_

2. **Varicella** (chicken pox) – 2 Vaccine dates required by CT law required for all students born after 1/1/1980.

#1 \_\_\_\_\_ (given on or after 1<sup>st</sup> Bday)

#2 \_\_\_\_\_ (given at least 28 days after the first)

**OR** Health care providers documentation of disease: Date: \_\_\_\_\_

**(Laboratory report must be attached for all titers showing immunity)**

Varicella antibody titer results \_\_\_\_\_ Date \_\_\_\_\_

3. **Meningococcal conjugate vaccine** – Given within the past 5 years as required for **Resident Students** by CT law.

Meningitis \_\_\_\_\_

4. **Tuberculosis testing** – Required within the past year.

**(Health care provider to fill out the Tuberculosis pages attached)**

5. **Hepatitis B** (Series of 3 vaccinations)

#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**(Laboratory report must be attached for all titers showing immunity)**

Hepatitis B antibody titer results \_\_\_\_\_ Date \_\_\_\_\_

6. Diphtheria/Pertussis/Tetanus (from within the past 10 years) \_\_\_\_\_

7. **Polio** (date series completed) \_\_\_\_\_

8. **Other vaccines:** \_\_\_\_\_

Health care provider \_\_\_\_\_ Signature & Date \_\_\_\_\_

# Post University Tuberculosis (TB) Assessment

Post Student Health Services

<http://post.edu/student-services/health-services>

|                          |                      |                                   |  |                            |
|--------------------------|----------------------|-----------------------------------|--|----------------------------|
| <b>Student Last Name</b> |                      | <b>Student First Name</b>         |  | <b>Student Middle Name</b> |
| <b>Date of Birth:</b>    | <b>Legal Gender:</b> | <b>Preferred Gender Identity:</b> |  | <b>Student ID</b>          |

YEAR BEGINNING AT POST \_\_\_\_\_  Fall  Spring

## TUBERCULOSIS (TB) RISK QUESTIONNAIRE (Questions a. through d. to be answered by the student)

|   |  |
|---|--|
| a) Have you ever had a positive tuberculosis skin or blood test in the past? <span style="color: red;">If YES, Go to Chest X-ray / Medication sections below</span>   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| c) Were you born in one of the countries listed below? <span style="color: blue;">If yes, please circle which one(s) below</span>                                     |  |
| d) Have you traveled to or lived for more than one month in one or more of the countries listed? <span style="color: blue;">If yes, please circle which one(s)</span> | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**IF you answered NO to all questions no further action is required.**

IF you answered YES to any question in b through d you must have a TB blood or skin test and provide the results below. A chest x-ray is not accepted for b through d YES answers.

No exemption for prior BCG. If you have received BCG in the past, a TB blood test is recommended however a TB skin test is accepted.

## TUBERCULOSIS (TB) TESTING (Results below to be documented by healthcare provider.)

**Testing and Chest X-ray (if required) must be done within 6 months prior to the start of school.**

| TB BLOOD TEST (IGRA)   | OR TB SKIN TEST (PPD)   | CHEST X-RAY   | MEDICATION TREATMENT  |
|--|---|---|---|
| <p style="color: red;"><i>Recommended if prior BCG</i></p> <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot<br><b>Date:</b> _____<br><br><b>Result:</b><br><input type="checkbox"/> NEG <input type="checkbox"/> POS | <p><b>Date Planted:</b> _____</p> <p><b>Date Read:</b> _____</p> <p><b>Interpretation:</b><br/>                     mm of induration: _____<br/> <input type="checkbox"/> NEG <input type="checkbox"/> POS                 </p> | <ul style="list-style-type: none"> <li>Only accepted/required if past or current positive TB skin or blood test.</li> <li>Not required if completed treatment for TB</li> </ul> <p><b>Chest X-ray Date:</b> _____</p> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | <input type="checkbox"/> Latent TB Infection<br><input type="checkbox"/> Active TB Infection<br><br><b>Date(s):</b> _____ |

**Signature of Health Care Practitioner (MD / DO / APRN / PA)**

Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_  
 Name (print) \_\_\_\_\_ Address \_\_\_\_\_

### List of High Risk Tuberculosis Countries

|  |   |   |   |   |
|--|---|---|---|---|
| Afghanistan<br>Algeria<br>Angola<br>Anguilla<br>Argentina<br>Armenia<br>Azerbaijan<br>Bangladesh<br>Belarus<br>Belize<br>Benin<br>Bhutan<br>Bolivia<br>Bosnia and Herzegovina<br>Botswana<br>Brazil<br>Brunei Darussalam<br>Bulgaria<br>Burkina Faso<br>Burundi<br>Cambodia<br>Cameroon<br>Cape Verde<br>Central African Republic<br>Chad<br>China<br>China, Hong Kong<br>China, Macao<br>Colombia | Comoros<br>Congo<br>Côte d'Ivoire<br>Democratic People's Republic of Korea<br>Democratic Republic of the Congo<br>Djibouti<br>Dominican Republic<br>Ecuador<br>El Salvador<br>Equatorial Guinea<br>Eritrea<br>Estonia<br>Ethiopia<br>Gabon<br>Gambia<br>Ghana<br>Greenland<br>Guam<br>Guatemala<br>Guinea<br>Guinea-Bissau<br>Guyana<br>Haiti<br>Honduras<br>India<br>Indonesia<br>Iraq | Kazakhstan<br>Kenya<br>Kiribati<br>Kuwait<br>Kyrgyzstan<br>Lao PDR<br>Latvia<br>Lesotho<br>Liberia<br>Libyan Arab Jamahiriya<br>Lithuania<br>Madagascar<br>Malawi<br>Malaysia<br>Maldives<br>Mali<br>Marshall Islands<br>Mauritania<br>Mauritius<br>Mexico<br>Micronesia<br>Mongolia<br>Montenegro<br>Morocco<br>Mozambique<br>Myanmar<br>Namibia<br>Nauru<br>Nepal | New Caledonia<br>Nicaragua<br>Niger<br>Nigeria<br>Northern Mariana Islands<br>Pakistan<br>Palau<br>Panama<br>Papua New Guinea<br>Paraguay<br>Peru<br>Philippines<br>Portugal<br>Qatar<br>Republic of Korea<br>Republic of Macedonia<br>Republic of Moldova<br>Romania<br>Russian Federation<br>Rwanda<br>Sao Tome and Principe<br>Senegal<br>Serbia<br>Sierra Leone<br>Singapore<br>Solomon Islands<br>Somalia<br>South Africa<br>Sri Lanka | Sudan<br>Suriname<br>Swaziland<br>Syrian Arab Republic<br>Taiwan<br>Tajikistan<br>Thailand<br>Timor-Leste<br>Togo<br>Tonga<br>Tunisia<br>Turkey<br>Turkmenistan<br>Tuvalu<br>Uganda<br>Ukraine<br>United Republic of Tanzania<br>Uruguay<br>Uzbekistan<br>Vanuatu<br>Venezuela<br>Viet Nam<br>Yemen<br>Zambia<br>Zimbabwe |
|--|---|---|---|---|

