Harrison Aldrich Wellness Center

Student Health Record
Immunizations- p. 1-2
TB Risk Assessment and testing evaluation- p. 3-4
Physical Exam- p. 5-6

Please note: The Student Health Record is to be filled out by a Health Care Provider and returned to Unity College prior to starting classes.

First Name ________________Middle Initial____ Last Name__________________________

Street Address
____

City_________________________State______________________Zip_____________________

Phone Number____

Date of Entry ____/____ Date of Birth ___/___/___ S.S. ______–______–_______

A. M.M.R. (Measles, Mumps, Rubella): Required
(Two doses required at least 28 days apart for students born after 1956)
- Dose 1 given at age 12 months or later #1 ___/___/___
- Dose 2 given at least 28 days after first dose #2 ___/___/___

B. Tetanus-Diphtheria-Pertussis: Required
(Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years.)
- Primary series of four doses with DTaP, DTP, DT, or Td:
  #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
- Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient ___/___/___
- Booster: Td within the last ten years ___/___/___

C. Hepatitis: Recommended
- Immunization (hepatitis A) Dose #1 ___/___/___ Dose #2 ___/___/___
- Immunization (Combined hepatitis A and B vaccine)
  Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
- Immunization (hepatitis B)
  Dose #1 ___/___/___ Dose #2 ___/___/___ c. Dose #3 ___/___/___

Student's Name ___________________________

D. Meningococcal Tetravalent: Recommended
(A,C,Y,W-135 / One dose — for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.)

Tetravalent conjugate (preferred; data for revaccination pending; administer simultaneously with Tdap if possible): Date ___/___/___

Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues): Date ___/___/___ ___/___/___

E. Quadrivalent or 9-Valent Human Papillomavirus Vaccine (HPV): Recommended
Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

F. Influenza: Recommended
(Trivalent inactivated influenza vaccine or TIV. Live attenuated influenza vaccine or LAIV; licensed for healthy, nonpregnant persons age 5-49 years old. Annual immunization recommended to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals. Health sciences students with patient contact.) Date ___/___/___

Health Care Personnel completing immunization record:

Print Name ____

Address ____

____

Signature ____

Phone ____

Student Health Record
TB Risk Assessment

Student's Name ______________________________________
Date of Birth ____________________________

***Please Note: The questions on page 3 are to be answered by the student. If student answers "yes" to any of the questions, the Health Care Provider is to complete page 4.**

PATIENT TO ANSWER THE FOLLOWING QUESTIONS:	YES	NO
To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?		
Have you ever had a positive TB skin test in the past?		
Were you born in any country other than the ones listed below?		
Have you traveled or lived for more than one month in a country other than Australia, Canada, Japan, New Zealand, U.S., or Western Europe?		

- If you answered YES to any of the four above questions, Unity College requires that you receive a TB skin test (PPD) and that a healthcare provider complete the reverse side of this form. **This must be done within 6 months prior to the start of classes (i.e. after February for students starting in September; after July for students starting in January)**

- If you answered NO to all of the above questions, you do not need a TB skin test.

- If you have had a positive TB skin test in the past, you do not need another test.

Student's Name ____________________________

Student Health Record

Tuberculosis (TB) Testing Evaluation

- If the patient answered YES to any of the four questions page 3, a PPD test is required **within 6 months prior to the start of classes**. If the test is positive, a chest x-ray is also needed within 6 months prior to the start of classes.
- If the patient has a history of a positive PPD test, a new PPD test is not necessary. A chest x-ray is needed within 6 months prior to the start of classes only if the patient has never been treated for latent TB.
- If the patient has completed treatment in the past, make a note of this in the treatment section below and no further testing or chest x-ray is required.
- Prior BCG does not exempt the patient from this requirement.

Tuberculin Skin Test (Use 5TU Mantoux test only.)
DATE READ: __/__/__
DATE PLANTED: __/__/__

Result (48-72hours):

- ☐ Negative __________mm induration
- ☐ Positive __________mm induration

Chest X-Ray (To be done if the PPD is positive.)
DATE: __/__/__

- ☐ Normal
- ☐ Abnormal (Describe) ____

Clinical Evaluation

- ☐ Normal
- ☐ Abnormal (Describe)____

Treatment

- ☐ No
- ☐ Yes (Drug, dose, frequency, and dates)
  ____

I certify that this patient has completed TB testing.

Healthcare Provider Signature ____________________________________

Print Name, Title____

Date____

Street Address____

City, State, Zip____

Student Health Record
Physical Exam

Student's Name: ______________________________ DOB: ____/____/______ Sex: M/F

Ht___________ Wt__________ BMI________ UA: Sugar _______ Albumin______
(if BMI>30, do UA)

Temp ________ Pulse________ Resp________ BP___/___
(if BP>140/90, do UA)

Are there any abnormalities of the following?

	No	Yes	Describe
HEENT			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Immune			
Neuropsychiatric			
Integumentary			

Are there any outstanding health issues we need to know about this student? Yes___ No___
Please explain.

____
____
____
____

Student's Name ______________________________

Do you have any recommendations regarding medical follow up? Yes___ No___

____
____
____
____

Is the student currently taking any medications? Yes___ No___
Please list medications with your instructions:

____
____
____
____

Does this student have any restrictions for physical activity? Yes___ No___
Please explain:

____
____
____
____

How long have you known this student? ____________________________________

Health Care Provider Information

Signature ____ Date ___________________

Printed Name ____

Address ____

____

Phone ___________________________

Revised January 31, 2019