

Welcome to Thomas More University. To ensure the health of all of our students, Thomas More complies with the recommendations of the American College Health Association (ACHA), and the Advisory Committee on Immunization Practices (ACIP) by requiring that all students:

1) Provide a copy of your **shot records** from your primary care physician and bring with you to the registration session.

The certificate must show proof of:

- ❖ 2 doses of MMR vaccine, if born after 1956. One dose must be after your 4th birthday.
- ❖ 4-5doses of DTP, or at least one dose after the 4th birthday.
- ❖ 3-4 doses of polio. If only 3 doses the 3rd dose must be after age 4.
- Tdap within the last 10 years.
- Varicella or evidence of immunity
- Meningococcal Meningitis
- 3 dose series of Hepatitis B
- Complete the student health information sheet. Attached is the form or go to http://www.thomasmore.edu/healthcenter/incoming_students.cfm and email the form to schatzt@thomasmore.edu

Please bring both forms listed above to the registration session or **fax them to 859-344-3636**. Students residing on campus and International students are **required** to submit vaccine records prior to arriving on campus. Any student who has not submitted immunization records **will not be permitted** to check in the resident's halls.

For the protection and welfare of all students, I ask that I be informed of any student with special needs (asthma, diabetes, epilepsy, depression...). Please provide any specific procedures you would like to have taken in the case of an emergency. You may use the back of the student health information form for any directions you may have.

All student health information and visits are strictly confidential and will not be discussed or released to any one without specific written permission from the student.

Unfortunately this includes parents and/or guardians, unless the student threatens their life or the life of someone else.

Feel free to contact me by phone at (859) 344-3529 or by e-mail at schatzt@thomasmore.edu with any questions regarding the above recommendations and/ or requirements or any other health related concerns you may have.

Sincerely,

Tammy Schatzman RN Director, Student Health Center Fax 859-344-3636 PLEASE EMAIL OR FAX COMPLETED FORM TO:

Medical History

Student ID #:	University Status:	Fresh So	phJr	_Sr1	
Resident or Commuter (circle)	Date of Birth	Date of Birth			
Name:					
Last Address:	First	MI		Maiden	
Address:	City	State	Zip Code		
Home Phone:					
Emergency Contact (capable of o		eatment in an e	mergency)		
Name:		Re	lationship		
Phone: (H)(W)	(Cell)			
Primary Care Physician					
Phone:					
Health Insurance					
Do you have health insurance? Carrier:	YesNo Policy #/Group #				
Policy Holder:		· · · · · · · · · · · · · · · · · · ·			
List all medications you currently take	e on a daily basis, or just a	s needed:			
List ALL drug allergies, your reaction	and the last time you read	cted:			

Medical HistoryPlease indicate, by checking the yes or no box, if you have a recent history of:

Yes	No		Yes	No	
		Frequent or Severe Headaches			Recurrent Back Pain
		Dizziness or Fainting Spells			Sprains and/or Strains
		Head Injury			High or Low Blood Pressure
		Skin Disease or Condition			Depression or Extreme Worry
		Jaundice or Hepatitis			Treatment for a Mental Health Condition
		Paralysis			Sexually Transmitted Infections
		Epilepsy or Seizures			Glasses or Contacts
		Diabetes type I or type II (please circle)			Broken Bones
		Hearing Loss			Heart Disorder(s)
		Hearing Aid			Sinusitis
		Asthma			Seasonal Allergies
		Allergy Injections			Tobacco Use
		Tuberculosis			Drug and/or Alcohol Abuse History
		Positive TB Skin Test			Eating Disorder
		Recent weight loss or weight gain			

Please elaborate on any item answered yes:					
Please note any injury or illness not listed above:					
Immunizations All student must provide a complete copy of childhoo office to fax a copy of your immunizations to the Can Privacy					
The information contained within this document is strictly for released to anyone without <u>your written consent</u> . My protect or other college personnel without my written authorization.	ted health information will not be shared with professors				
I understand that Health Services may consult with colleaguincluding counseling staff and other clinical personnel (e.g. a team.					
I understand that I have the right to restrict the use and dis may revoke my consent at any time by giving written notific					
YES NO I consent to information regarding my ca	re to be transmitted electronically (e.g. through pate in telehealth visits.				
I certify that the above information is true and complete to University Campus Health Center consent to perform routine procedures; and to use their best judgment in securing emethat I am financially responsible for any and all medical expenses.	e medical care and necessary emergency care ergency medical aid and/or transportation. I understand				
Student or Parent signature if under 18	Date				
Student Signature	Date				
Parent Signature - if student is under 18	 Date				

For Resident Hall Students ONLY

Name		Γ	OB	/_	/	
TODA	AY'S DATE//	_ Student II) #:			
	ERCULOSIS (TB) SCREENING answer the following questions:	G/TESTING (RE	QUIRI	E D)		
Has aı	nyone in your family or other clos YES NO	se contact had tub	erculosi	s (TB)?		
Have	you ever had a positive TB test? YES NO					
Have	you ever been on medication to tr YES NO	reat TB?				
*Have	If yes, did you complete the treate you ever spent more than two m YES NO				?	
	If yes, when?e list the country(s) in which you ational students: Have you ever h YES NO					ine
*In wl	hat country were you born?					
Have	you ever worked or volunteered i YES NO	n a prison/jail?				
Have	you ever provided patient care in YES NO	a nursing home, l	ospital	or other	health ca	are facility?
Have	you ever worked or volunteered i YES NO	n a residential fac	ility for	patients	with AI	DS?
*Signi provid	ificance of travel exposure and/or ler.	r country of origin	should	be disci	issed wit	h a health care
Check	if you have any symptoms listed Cough (especially if lasting for 3 w or longer) with or without sputum production Coughing up blood (hemoptysis) Chest pain	eeks \Box	l Unex l Nigh	t sweats	te weight los	os

If you were born in the United States and answered NO to all above questions, no further action is required.

<u>Persons answering YES</u> to any of the above questions are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test is documented. Tuberculin Skin Test (TST)
Date Given:/ Date Read/ Resultmm of induration
Interferon Gamma Release Assay (IGRA)
Date Obtained:/ Specify method: QFT-GIT T-spotother
Result:negativepositiveindeterminateborderline (T-spot only)
Chest x-ray Date of chest x-ray:/ Result:normalabnormal (Please attach CXR report)

schatzt@thomasmore.edu

Questions? Contact Campus Health Services 859-344-3529