

Christian Brothers University Student Health Form

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. IT MUST BE RETURNED TO:

Health Resources, Christian Brothers University • 650 East Parkway South, Box T-4 • Memphis, Tennessee 38104

Telephone 901-321-3260 / FAX 901-321-3524

PERSONAL INFORMATION

Resident Commuter

Last Name _____ First _____ Middle Initial _____

SS# _____ - _____ - _____ Age _____ Sex _____ Date of Birth _____ / _____ / _____

THE PRE-ENTRANCE MEDICAL REPORT AND EXAMINATION ARE REQUIRED OF ALL STUDENTS entering Christian Brothers University. This record is to be filled out and signed by your personal physician. All information is strictly confidential and is obtained for the purpose of insuring adequate health care for the student in the event of illness or emergency. Also, if there are any reasons that the student cannot participate in regular university activities including physical education, they must be noted by the physician. We strongly recommend some type of health insurance so that proper and prompt treatment will be available if the need arises.

DATA AND HISTORY

(Please answer each question) Date of University Entrance _____

Home Address _____

Parent/Guardian Name _____

Parent/Guardian Home Address _____

Parent/Guardian Business Address _____

Home Telephone (_____) _____ Business Telephone (_____) _____

Health Insurance Company _____

Policy Number _____ Telephone (_____) _____

In Case of Emergency, Notify _____

Relation _____ Telephone (_____) _____

PHYSICAL EXAMINATION

[PLEASE NOTE that this exam may be used as a sports physical in the event this student chooses to participate in athletics at Christian Brothers University.]

Date of Exam _____ / _____ / _____ Height _____ Weight _____ BP _____ Pulse _____ Temp _____

Indicate if normal / Describe if abnormal

Head _____ Abdomen (Hernia) _____

EENT _____ G.I. _____

Dental _____ GU _____

Neck _____ Musculoskeletal _____

Heart _____ Lungs _____

Hct _____ Blood Glucose _____ UA...Sp.Gr _____ Albumin _____ Micro _____

Hx of Surgery, Hospitalization, or Chronic Illness

Describe and give dates _____

Medications Taken on a Regular Basis _____

Allergies to: Medications / Other _____

Activity Exemption _____

Any condition / disability that would limit this student's physical activity

PLEASE TURN OVER AND COMPLETE REVERSE SIDE

Name _____ DOB _____ SS# _____

IMMUNIZATION REQUIREMENTS

ATTACHED DOCUMENTS ARE ACCEPTABLE

Td (Tetanus Diphtheria) / Date of Last Dose _____ / _____ / _____ (within ten years)

MMR (Measles, Mumps, Rubella; **2 Doses Required**) Dose 1 _____ / _____ / _____ Dose 2 _____ / _____ / _____

Polio / Date of Last Dose _____ / _____ / _____ Indicate Type OPV IPV

Tuberculin Skin Test / **Date Within One Year of Admission**

Test date _____ / _____ / _____ Reading date _____ / _____ / _____ Result _____ mm

The General Assembly of the State of Tennessee mandates that each public or private postsecondary institution in the state provide information concerning hepatitis B infection to all students entering the institution for the first time. Those students who will be living in on-campus housing must also be informed about the risk of meningococcal meningitis infection. The required information below includes the risk factors and dangers of each disease as well as information on the availability and effectiveness of the respective vaccines for persons who are at-risk for the diseases. The information concerning these diseases is from the Centers for Disease Control and the American College Health Association. **The law does not require that students receive vaccine for enrollment. Furthermore, the institution is not required by law to provide vaccination and/or reimbursement for the vaccine. IF YOU ELECT NOT TO RECEIVE THESE IMMUNIZATIONS, THE WAIVERS BELOW MUST BE SIGNED.**

Hepatitis B / Dates: Dose 1 _____ / _____ / _____ Dose 2 _____ / _____ / _____ Dose 3 _____ / _____ / _____

Meningococcal Meningitis / Date _____ / _____ / _____

A. WAIVER OF HEPATITIS B (HBV) IMMUNIZATION

Hepatitis B (HBV) is a serious viral infection of the liver that can lead to chronic liver disease, cirrhosis, liver cancer, liver failure, and even death. The disease is transmitted by blood and/or body fluids and many people will have no symptoms when they develop the disease. The primary risk factors for Hepatitis B are sexual activity and injecting drug use. This disease is completely preventable. Hepatitis B vaccine is available to all age groups to prevent Hepatitis B viral infection. A series of three (3) doses of vaccine are required for optimal protection. Missed doses may still be sought to complete the series if only one or two have been acquired. The HBV vaccine has a record of safety and is believed to confer lifelong immunity in most cases.

I hereby certify that I have read the information and **I have elected NOT to receive the Hepatitis B vaccine.**

Signature _____ Date: _____ / _____ / _____

Student (or Parent/Guardian if student is under age 18):

B. WAIVER OF MENINGOCOCCAL MENINGITIS IMMUNIZATION

Meningococcal disease is a rare but potentially fatal bacterial infection, expressed as either meningitis (infection of the membranes surrounding the brain and spinal cord) or meningococemia (bacteria in the blood). Meningococcal disease strikes about 3,000 Americans each year and is responsible for about 300 deaths annually. The disease is spread by airborne transmission, primarily by coughing. The disease can onset very quickly and without warning. Rapid intervention and treatment is required to avoid serious illness and/or death. There are 5 different subtypes (called serogroups) of the bacterium that causes Meningococcal Meningitis. The current vaccine does not stimulate protective antibodies to Serogroups B, but it does protect against the most common strains of the disease, include serogroups A, C, Y and W-135. The duration of protection is approximately three to five years. The vaccine is very safe and adverse reactions are mild and infrequent, consisting primarily of redness and pain at the site of injection lasting up to two days. The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that college freshmen (particularly those who live in dormitories or residence halls) be informed about meningococcal disease and the benefits of vaccination and those students who wish to reduce their risk for meningococcal disease be immunized. Other undergraduate students who wish to reduce their risk for meningococcal disease may also choose to be vaccinated.

I hereby certify that I have read the information and **I have elected NOT to receive the vaccine for Meningococcal Meningitis**

Signature _____ Date: _____ / _____ / _____

Student (or Parent/Guardian if student is under age 18):

AUTHORIZATION FOR TREATMENT & RELEASE OF INFORMATION

I hereby authorize Christian Brothers University to gain professional medical treatment for the student here mentioned in the event of an emergency, until such time as the previously listed person(s) can be notified. **I further authorize CBU Health Services to release a copy of this form to the Athletics Department in the event this student chooses to participate in college athletics.**

Student's Signature _____ Date _____ / _____ / _____

Parent/Guardian Signature _____ Date _____ / _____ / _____

Physician's Signature _____

Physician's Name (Please Print or Type) _____

Professional Address _____

Office Telephone (_____) _____