OFFICE USE ONLY
Date Received ________________

	Health Record	
	TB Screening	
	Immunizations	
	Meningitis vaccine	
	SS/Notify Admis.	

HEALTH RECORD

TRINITY UNIVERSITY

CLASSIFICATION
Date Enrolled_______________________

	First Year
	Sophomore
	Junior
	Graduate
	Transfer/exchange/international

INSTRUCTIONS: Type or print answers. Write your name on every page. Pages 2 through 4 MUST be completed by your healthcare provider within the 12 months prior to matriculation. Health Records are due July 1, 2020. Health Insurance is required. New students will be billed for the Student Health Insurance Plan on the bill for Fall semester. If you have personal insurance you must submit an insurance waiver at trinity.myahpcare.com, beginning in July until the end of Add/Drop in August. After this date, refund of the premium will not be available. If waiving insurance attach a copy of your health insurance card, front & back.

STUDENT'S LEGAL NAME: ____ **Trinity ID#** ________________
Last First Middle

Date of Birth__________ Sex Assigned at Birth_____ Chosen Gender Identity_____ Marital status ____ SS#____________________
mm/dd/yyyy

Home Address____ Citizenship__________________________

City ____________________________________ State _____ Zip _________ Student's Cell Phone_____________________

PARENT OR GUARDIAN ____Relationship ______________________________

Street Address ____ Home Phone __________________________

City_________________________________State _______ Zip _____________ Work Phone __________________________

FAMILY HISTORY

Father: Living____ Deceased_____

Occupation __________________

Mother: Living____ Deceased_____

Occupation ___________________

Siblings: #Living____ #Deceased_____

Have any of your relatives had any of the following?
Circle Yes or No Relationship (if yes)

No	Asthma	Yes______________________________
No	Heart Disease	Yes______________________________
No	Cancer	Yes______________________________
No	Diabetes	Yes______________________________
No	Kidney Disease	Yes______________________________
No	Seizure Disorder	Yes______________________________
No	Mental Illness	Yes______________________________
No	Tuberculosis	Yes______________________________
No	Other: Specify	______________________________

PERSONAL MEDICAL HISTORY: Have you ever had or do you have any of the following? Indicate **Yes or No**, comment on positive answers.

Y or N		Y or N		Y or N		Explanation and Dates
	Anxiety/Depression		Hepatitis/Jaundice		Scarlet Fever	
	Asthma		Hi/Lo Blood Pressure		German Measles (Rubella)	
	Bleeding Disorder		Kidney/Bladder Disease		Measles (Rubeola)	
	Bone Joint Disease		Mononucleosis		Mumps	
	Cancer		Peptic Ulcer		Chicken Pox	
	Chronic Cough		Psychiatric Treatment		Malaria	
	Contact Lenses		Recent Weight Change		**ALLERGIES**	
	Diabetes		Seizures/Blackouts		Penicillin	
	Disabilities		Sexually Transmitted Dis.		Other Antibiotics	
	Eating Disorder		Thyroid Diseases		Sulfa	
	Female or Menstrual Problem		Tuberculosis		Codeine	
	Gum/Dental Disorder		Other Health Problems		Aspirin	
	Head Injury		Tonsillectomy		Foods	
	Headaches, Recurrent		Appendectomy		Seasonal Pollen	
	Hearing Aid		Hernia Repair		Wasp/Bee Stings/Fire Ants	
	Heart Disease		Other Operations		Other:	

STATEMENT OF CONSENT FOR TREATMENT & CONFIDENTIALITY: *PLEASE INITIAL* each line and SIGN at bottom

________ I give consent for Trinity University Health Services to administer medical and surgical services, including immunizations and allergy injections, and to perform routine and emergency diagnostic and therapeutic procedures as deemed necessary by duly licensed medical personnel, if I present to Health Services requesting services.

________ I understand that all protected health information possessed by TUHS is confidential and will not be disclosed or released without my specific written permission except when used for treatment, payment or other health care operations or as required by law.

________ I grant permission to contact me by phone or email for follow up or reminders. For more information regarding privacy policies and patient rights contact Health Services; Privacy Notice available online at http://inside.trinity.edu/student-success/health-services/privacy-statement.

________ I authorize the release of health insurance information to the Intramural Offices, Athletic Trainer, and Student Financial Services.

________ I understand that this consent shall remain in effect the entire time I am a student at Trinity University, but may be withdrawn in writing.

_______________________________________ _______________________________________
Signature of Student Date Signature of Parent if student under age 18 Date

TO THE EXAMINING PHYSICIAN OR HEALTHCARE PROVIDER: We appreciate your thoroughness in reviewing the patient's medical history and completing **PAGES 2 THROUGH 4** of this form -- including a physical examination (within the 12 months prior to matriculation), tuberculosis screening and documentation of immunizations. ***SIGN ALL 3 PAGES***.

Date of Examination____/____/____ (Must be within 12 months of entering school)
mm/dd/yyyy

STUDENT NAME____ **Gender** ______________________
LAST FIRST M.I.

Weight __________ **Height** __________ **Blood Pressure** __________ **Pulse** _________

Evaluate the following systems and note abnormalities:

NORMAL (☑)	ABNORMAL FINDINGS (Explain)
________	Head, Ears, Nose or Throat
________	Respiratory
________	Cardiovascular
________	Gastrointestinal
________	Eyes (Refractive)
________	Eyes (Other)
________	Genitourinary
________	Musculoskeletal
________	Metabolic/Endocrine
________	Skin
________	Joint Function

Is student being treated for any medical conditions?

____

____

Is the student being treated for any psychological conditions?

____

____

Name and dosage of current medications:

____ ____

____ ____

____ ____

____
Name of Physician or Healthcare Provider **PRINTED or office stamp**

Street Address ________________________________

City, State, Zip ________________________________

Phone Number________________________________

____
Signature of Physician or Healthcare Provider

CONTINUED ON NEXT PAGE

TUBERCULOSIS SCREENING: Questions 1 & 2 Required; Actual testing may not be necessary but form *MUST BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER* within the 6 months prior to matriculation.

STUDENT NAME____**Date of screening**____________

LAST FIRST M.I. mm/dd/yyyy

1. **Does the student have signs or symptoms of active TB disease? Check one** (Unexplained persistent cough, night sweats, weight loss, chills or fever, fatigue, hemoptysis, loss of appetite or exposure to TB) **Check one**

☐ **NO**, Proceed to Question 2.

☐ **YES**, Proceed to Item 3, additional evaluation required to exclude active TB disease (including Tuberculin skin testing, IGRA, chest x-ray and sputum evaluation, as indicated).

2. **Was the student born in or recently arrived from a country other than those listed below* or a member of a high-risk group**? Check one**

☐ **NO, SIGN AND DATE BOTTOM OF PAGE.** Do not perform a TB skin test.

☐ **YES**, Check one or more below, as appropriate. Then proceed to Item 3

☐ If no previous positive test then Mantoux must be administered within 6 months of matriculation.

☐ If prior positive Mantoux test, Date of Positive TB test _____/_____/_____, then Interferon Gamma Release Assay (IGRA) or chest x-ray required, mm/dd/yyyy

☐ A history of BCG vaccination should not preclude testing of a member of a high-risk group; If patient has received BCG provide date of last dose BCG _____/_____/_____. mm/dd/yyyy

*Categories of high-risk students include those students who have arrived within the past 5 years or were born in countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: American Samoa, Andorra, Antigua and Barbuda, Aruba, Australia, Austria, Bahamas, Bahrain, Barbados, Belgium, Bermuda, Bonaire, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Isl., Costa Rica, Croatia, Cuba, Curacao, Cyprus, Czechia, Denmark, Dominica, Egypt, Estonia, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Iran, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxembourg, Malta, Mauritius, Monaco, Montenegro, Montserrat, Netherlands, New Zealand, New Caledonia, Norway, Oman, Poland, Puerto Rico, Saint Eustatius, Saint Kitts and Nevis, Saint Lucia, Saint Vincent, Samoa, San Marino, Saudi Arabia, Serbia, Seychelles, Sint Maarten, Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab, The Former Yugoslav Repub. of Macedonia, Tokelau, Tonga, Trinidad and Tobago, Turkey, Turks and Caicos Islands, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, USA, US Virgin Isl.,Wallis and Futuna Isles., West Bank and Gaza Strip.

**Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone $\geq$ 15 mg/d for $\geq$ 1 month) or other immunosuppressive disorders.

3. **If question 1 or 2 YES, Mantoux Tuberculin skin test Or Interferon Gamma Release Assay (IGRA) required** (within 6 months of matriculation)

TB Skin test: Date given: ____/____/_____ (must be within 6 months of matriculation) mm/dd/yyyy

Date read: ____/____/______ **Result:** __________ **mm** (Record mm of induration, transverse diameter, if no induration write "0") mm/dd/yyyy

Interpretation: o positive o negative (based on mm of induration as well as risk factors)

IGRA: Date Obtained: ____/___/___ Attach copy of results/lab report mm/dd/yyyy

4. **Chest X-ray** (required if tuberculin skin test or IGRA is positive): Date of chest x-ray: ____/____/____ mm/dd/yyyy

Result: o normal o abnormal

Does the patient require additional follow up or treatment for Latent TB Infection? ___________

VERIFICATION OF SCREENING BY HEALTH CARE PROVIDER

_________________________________ ______________ _____________________________________

Signature of Healthcare Provider Date Printed Name or Office Stamp

The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from Centers for Disease Control and the American Thoracic Society. For more information, visit http://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis Screening.pdf or refer to the CDC's Core Curriculum on Tuberculosis http://www.cdc.gov/tb/education/corecurr/index.htm. **CONTINUED ON NEXT PAGE**

IMMUNIZATIONS REQUIRED. TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER or attach an official copy of the student's immunization records.

STUDENT NAME___________________________________ **Date of Birth** _____/_____/________
LAST FIRST M.I. **mm/dd/yyyy**

TRINITY ID #_____________________________

Required vaccines:

For All Students under 22 years of age

- **MENINGOCOCCAL TETRAVALENT Conjugate (MCV4)** (Preferred) Date ______/______/_________ mm/dd/yyyy Must be within the 5 years prior to the first day of classes.
  OR **Polysaccharide vaccine (MPSV4)** Date ______/_____/_________ mm/dd/yyyy
  Texas law requires this vaccination to be received at least 10 days before the start of class and within the 5 years preceding the first day of class. *(May attach required documentation) See guidelines at http://inside.trinity.edu/sites/inside.trinity.edu/files/file_attachments/24/trinityu-meningitis-vaccine-guidelines-oct-13.pdf*

For All Students living on campus

- **POLIO (IPV/OPV) Date** ______/______/_________ mm/dd/yyyy
  Date required if under 18 years of age

- **TETANUS-DIPHTHERIA (Td)** Date ______/______/_________ mm/dd/yyyy
  OR **TETANUS-DIPHTHERIA-PERTUSSIS (Tdap)** Date ______/______/__________ mm/dd/yyyy
  Must have received within past ten (10) years

- **MEASLES, MUMPS, RUBELLA (MMR)** *(two doses required)*
  Dose 1______/______/_________ mm/dd/yyyy **Dose 2**______/______/_________ mm/dd/yyyy
  (Given at age 12-15 months or later) *(Given at age 4-6 years or later, and at least one month after first dose)*

Recommended vaccines: Students are encouraged to have these vaccinations but they are not required. Record all dates as mm/dd/yyyy

- **HEPATITIS B VACCINE**

Dose 1 ______/______/_________ Dose 2 ______/______/________ Dose 3 ______/______/________

- **HEPATITIS A VACCINE**

Dose 1 ______/______/__________ Dose 2 ______/______/__________

- **VARICELLA** (If no history of Chicken Pox or negative Varicella Antibody)

Dose 1 _____/_____/__________ Dose 2 ____/____/__________ (given at least one month after first dose, if age 13 years or older)

- **Human Papillomavirus Vaccine, 4vHPV, 9vHPV, OR Bivalent,** Please circle one

Dose 1 _____/_____/__________ Dose 2 _____/_____/__________ Dose 3 _____/_____/_________

- **MENINGOCOCCAL SEROGROUP B** Circle one: MenB-RC (Bexsero, 2 doses) or MenB-FHpb (Trumenba, 2 or 3 doses)
  For students at increased risk, Must complete series with same vaccine

Dose 1______/______/______ **Dose 2** ______/______/______ **Dose 3 (if needed)** ______/______/______,

VERIFICATION OF IMMUNIZATIONS BY HEALTHCARE PROVIDER

_______________________________________ ____________ ______________________________________

Signature of Healthcare Provider Date mm/dd/yyyy Printed Name or Office Stamp

When all 4 pages are complete and signed, return this form with a copy of the front and back of your personal health insurance card to:

TRINITY UNIVERSITY HEALTH SERVICES
ONE TRINITY PLACE #80
SAN ANTONIO, TEXAS 78212-4674

PHONE: (210) 999-8111
FAX: (210) 999-8378
EMAIL: healthservices@trinity.edu