

BIRMINGHAM-SOUTHERN COLLEGE

STUDENT HEALTH FORM

(This portion to be completed by the student – Return within 30 days prior to enrollment)
Please use a ball point pen – Do not detach pages.

Application for: (Check One) Fall Interim Spring Summer 20____

Class: (Check One) Freshman Sophomore Junior Senior

(Student's last name) (First) (Middle) (Preferred Name) M F

Date of Birth: _____ Age: _____

Parent(s)/Guardian(s): _____ Phone: (home): _____ (work) _____

Complete Home Address: _____

In case of an emergency, call: _____ (phone) _____ (phone) _____

Relationship: _____

*Parent's Insurance Company (if student insured) _____ Policy # _____

(Please provide photo-copy of the front and back of insurance card), Health insurance is required for all BSC students

FAMILY HISTORY: Has any member of your family had: (Check appropriately) Diabetes Heart Disease Epilepsy
 Hypertension Mental Illness Other _____

PREVIOUS HISTORY: Please give date of any of the following that you have had, or indicate if currently exist.

Asthma _____	Diabetes _____	Rubella (German Measles) _____	Have you every had? _____
Bone/Joint Disease _____	Heart Disease _____	Rubeola (Measles) _____	Anxiety or depression _____
Hay Fever _____	Hypertension _____	Mumps _____	Sleep difficulty _____
Hepatitis _____	Rheumatic Fever _____	Tuberculosis _____	Eating disorder _____
Anemia _____	Epilepsy _____	Cancer _____	Alcohol/drug problem _____
Frequent Ear Infection _____	Seizures _____	Severe Headaches _____	Learning disability _____
Infectious Mono _____	Kidney Disease _____	Menstrual Difficulties _____	ADD/ADHD _____
Dizziness/Fainting _____	Chicken Pox _____	Sexually Transmitted Diseases _____	
Attention Deficit Disorder _____	Learning Disability _____	Hyperactivity _____	
Other _____			

● List and give dates of any **major** operations and injuries: _____

PRESENT HEALTH: Excellent Good Fair Poor Date of last thorough examination: _____

● Medication taken: Regularly _____ Periodically _____

● Any medication allergy? _____ Other allergies? _____

● Have you lost weight in the last year? yes no If yes, how much? _____

● Do you feel any ill effects from active exercise? yes no If yes, what? _____

● Have you ever been advised NOT to participate in any type of athletics? yes no If yes, why? _____

● List any symptoms now present, or which trouble you at frequent intervals: _____

● Give details of any illness or medical condition that requires regular treatment or alteration in your manner of living: _____

Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression, or other emotional problem? (Give details & name of attending physician.) _____

Student's Signature

Physician's Signature

MEDICAL EXAMINATION

Name _____ Birth date ____/____/____

(This portion to be completed by the physician. Please use a ball point pen – DO NOT detach pages.)

Weight _____ Height _____ Pulse _____ Blood Pressure ____/____ Temperature _____

Vision: Right Eye _____ Left Eye _____ (20/20, etc. Eye Chart)

Physical Examination:

Cardiovascular _____ Musculoskeletal _____ Ears _____
Respiratory _____ Nervous _____ Nose _____
Gastrointestinal _____ Reproductive _____ Throat _____
Integumentary _____ Other _____ Mouth _____

General Development: Excellent Good Fair Poor

Is there any restriction or recommendation due to chronic condition of medical problem? no yes If yes, give reason and extent of restriction. _____

IMMUNIZATION RECORD

Up-to-date immunizations are required for enrollment. Must be completed and signed by physician.

MMR (Measles, Mumps, Rubella) (2 doses are required if born on or after January, 1957)

Dose 1 (administered at age 12-15 months or later) ____/____
Mo. Yr.

Dose 2 (administered at age 4-6 years) ____/____
Mo. Yr.

DTP (Diphtheria, Tetanus, Pertussis)

1) Primary series of four doses with DTaP or DTP Dose 1 ____/____ Dose 2 ____/____
Mo. Yr. Mo. Yr.

Dose 3 ____/____ Dose 4 ____/____
Mo. Yr. Mo. Yr.

2) Td (Tetanus-Diphtheria) booster within the last 10 years ____/____
Mo. Yr.

POLIO 1) Date initial series completed ____/____ 2) Last booster ____/____
Mo. Yr. Mo. Yr.

TUBERCULIN SKIN TEST – See Tuberculosis Screening/Testing/Risk Assessment Forms

1) PPD (Mantoux) within the last 12 months (tine or monovac not acceptable) ____/____
Mo. Yr.

Results: Negative Positive mm induration (horizontal diameter) _____

2) If PPD is positive, chest x-ray required ____/____ X-ray results: Normal Abnormal
Mo. Yr.

MENINGOCOCCAL Quadrivalent Polysaccharide Vaccine ____/____
Mo. Yr.

VARICELLA (Either a history of Chicken Pox, a positive Varicella antibody, or 2 doses of vaccine given at least one month apart if immunized after age 13 years meets the requirements)

1) History of Disease Yes No

2) Immunization Dose 1 ____/____ Dose 2 ____/____
Mo. Yr. Mo. Yr.

3) Varicella Antibody ____/____ Result: Reactive Non-reactive
Mo. Yr.

—RECOMMENDED IMMUNIZATIONS—

HEPATITIS B (in 3 doses) OR POSITIVE HEPATITIS SURFACE ANTIBODY

(Recommended for Pre-Health, Pre-Med students)

1) Dose 1 ____/____ Dose 2 ____/____ Dose 3 ____/____
Mo. Yr. Mo. Yr. Mo. Yr.

2) Hepatitis B surface antibody ____/____ Result: Reactive Non-reactive
Mo. Yr.

Physician Signature _____

Date _____

Phone Number _____

Physician Address _____

INTERNATIONAL STUDENTS MUST PROVIDE ENGLISH TRANSLATION

Return All Copies to Birmingham-Southern College, Admission, Box 549008, Birmingham, AL 35254

K. TUBERCULOSIS (TB) SCREENING/TESTING¹

Please answer the following questions:

Have you ever had a positive TB skin test? Yes _____ No _____

Have you ever had close contact with anyone who was sick with TB? Yes _____ No _____

Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? Yes _____ No _____
(If yes, please circle the country)

Have you ever traveled* to/in one or more of the countries listed below? Yes _____ No _____
(If yes, please check the country/ies)

Have you ever been vaccinated with BCG? Yes _____ No _____

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

Afghanistan	Cook Islands	Kazakhstan	Nigeria	Syrian Arab Republic
Algeria	Côte d'Ivoire	Kenya	Pakistan	Tajikistan
Angola	Croatia	Kiribati	Palau	Thailand
Argentina	Democratic People's Republic of Korea	Kuwait	Panama	The former Yugoslav Republic of Macedonia
Armenia	Democratic Republic of the Congo	Kyrgyzstan	Papua New Guinea	Timor-Leste
Azerbaijan	Djibouti	Lao People's Democratic Republic	Paraguay	Togo
Bahrain	Dominican Republic	Latvia	Peru	Tonga
Bangladesh	Ecuador	Lesotho	Philippines	Trinidad and Tobago
Belarus	El Salvador	Liberia	Poland	Tunisia
Belize	Equatorial Guinea	Libyan Arab Jamahiriya	Portugal	Turkey
Benin	Eritrea	Lithuania	Qatar	Turkmenistan
Bhutan	Estonia	Madagascar	Republic of Korea	Tuvalu
Bolivia (Plurinational State of)	Ethiopia	Malawi	Republic of Moldova	Uganda
Bosnia and Herzegovina	French Polynesia	Malaysia	Romania	Ukraine
Botswana	Gabon	Maldives	Russian Federation	United Republic of Tanzania
Brazil	Gambia	Mali	Rwanda	Uruguay
Brunei Darussalam	Georgia	Marshall Islands	Saint Vincent and the Grenadines	Uzbekistan
Bulgaria	Ghana	Mauritania	Sao Tome and Principe	Vanuatu
Burkina Faso	Guam	Mauritius	Senegal	Venezuela (Bolivarian Republic of)
Burundi	Guatemala	Micronesia (Federated States of)	Serbia	Viet Nam
Cambodia	Guinea	Mongolia	Seychelles	Yemen
Cameroon	Guinea-Bissau	Montenegro	Sierra Leone	Zambia
Cape Verde	Guyana	Morocco	Singapore	Zimbabwe
Central African Republic	Haiti	Mozambique	Solomon Islands	
Chad	Honduras	Myanmar	Somalia	
China	India	Namibia	South Africa	
Colombia	Indonesia	Nepal	Sri Lanka	
Comoros	Iraq	Nicaragua	Sudan	
Congo	Japan	Niger	Suriname	
			Swaziland	

Source: World Health Organization, Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://apps.who.int/ghodata/?vid=510>

If the answer is YES to any of the above questions, _____ requires

Insert the name of your college/university

that a health care provider complete a tuberculosis risk assessment (to be completed within 6 months prior to the start of classes).

If the answer is to all of the above questions is NO, no further testing or further action is required.

¹The American College Health Association has published guidelines on "Tuberculosis Screening and Targeted Testing of College and University Students." To obtain the guidelines, visit www.acha.org.

(continued)

TUBERCULOSIS (TB) RISK ASSESSMENT

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Recent close contact with someone with infectious TB disease Yes _____ No _____

Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)
Yes _____ No _____

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease Yes _____ No _____

HIV/AIDS Yes _____ No _____

Organ transplant recipient Yes _____ No _____

Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- α antagonist) Yes _____ No _____

History of illicit drug use Yes _____ No _____

Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) Yes _____ No _____

Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)] Yes _____ No _____

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

1. **Does the student have signs or symptoms of active tuberculosis disease?** Yes _____ No _____
If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____
M D Y

Date Read: ____/____/____
M D Y

Result: _____ mm of induration **Interpretation: positive _____ negative _____

Date Given: ____/____/____
M D Y

Date Read: ____/____/____
M D Y

Result: _____ mm of induration **Interpretation: positive _____ negative _____

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-G QFT-GIT T-Spot other _____
M D Y

Result: negative _____ positive _____ indeterminate _____ borderline _____ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-G QFT-GIT T-Spot other _____
M D Y

Result: negative _____ positive _____ indeterminate _____ borderline _____ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal _____ abnormal _____
M D Y

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF- α antagonist
- Persons with HIV/AIDS

*The significance of the travel exposure should be discussed with a health care provider and evaluated.

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

HEALTH CARE PROVIDER

Name _____

Signature _____

Address _____

Phone (____) _____