Student Health Data

All students must complete and submit the enclosed health forms.

Birmingham-Southern College, Health Services, Box 549042. Birmingham, AL 35254

To assist the Department of Health Services in providing the best care for all BSC students, it is important to complete the required health forms attached.

1. Please use ballpoint pen and return to Health Services by July 15.
2. All students must complete these required forms. Student athletes also submit additional health information to Athletics.
3. The student fill out pages 3 and 4.
4. Your Physician fills out pages 5 and 6 (TB test dependent on information filled out by student on page 7.)
5. Students exempt from immunizations must provide an exemption form.
6. International students must provide English translation for medical records submitted.
7. All students are required to have health insurance. Please include a copy of the front and back of your insurance card.
8. **Please retain a copy of your health information for your own records**.

Forms may be:

Mailed to : Birmingham-Southern College, Health Services. Box 549042, Birmingham, AL 35254

Faxed to: 205-226-3084

Scanned and emailed to: healthservices@bsc.edu

Health Services

Proof of Insurance

BSC students are required to maintain health insurance, for which they must provide proof. If you do not have a family health insurance plan, you will need to purchase a personal coverage plan offered by a health insurance company or visit the insurance Marketplace, https://www.healthcare.gov, to review plans offered.

We encourage you to check with your insurance carrier to ensure you have health care coverage in the Birmingham area, particularly if your coverage originates outside of the area.

Please attach a photocopy of the front and back of your insurance card to this form.

Student Health Data

Health Services

This portion to be completed by the student—Return by July 15– Please use ballpoint pen.

Start Term: □ Fall □ Exploration □ Spring □ Summer □ Year _____

Class Year: □ Freshman □ Sophomore □ Junior □ Senior □ Transfer

Full Name : _____ Preferred: _____

(first) (middle) (last)

Permanent Address: _____

(street) (city) (state) (zip)

Sex: □ Male □ Female □ Prefer Not To Answer Date of Birth _____

Parent/Guardian _____ Parent/Guardian _____

Home Phone _____ Home Phone _____

Cell Phone _____ Cell Phone _____

Emergency Contact (if different from above)

_____

(name) (cell) (other phone) (relationship to student)

<u>Current Medications:</u>

Medications taken regularly: _____

(prescription name) (dosage) (frequency)

_____

(prescription name) (dosage) (frequency)

Medications taken periodically: : _____

(prescription name) (dosage) (frequency)

_____

(prescription name) (dosage) (frequency)

Consent to Provide Medical Treatment

I hereby authorize Birmingham-Southern College to treat all injuries and illnesses for which help is sought as deemed necessary by licensed personnel, including immunizations and medical emergencies.

Student's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

Student Health Data

Health Services

This portion to be completed by the student—Return by July 15– Please use ballpoint pen.

Family History

Has any member of your family had:

□ Diabetes □ Heart Disease □ Hypertension □ Epilepsy □ Mental Illness □ Other: _____

Personal Medical History

Please provide date (month/year) of the following medical issues and note if an ongoing medical condition:

__ Asthma	___ Hypertension	Have you ever had?
__ Hepatitis	___ Seizures	____ Anxiety or Depression
__ Anemia	___ Kidney Disease	____ Sleep Difficulty
__ Frequent Ear Infection	___ Chicken Pox	____ Eating Disorder
__ Infectious Mono	___ Learning Disability	____ Alcohol/Drug Issues
__ Dizziness	___ Cancer	
__ Fainting	___ Severe Headaches/Migraines	Other:
__ Attention Deficit Disorder	___Menstrual Difficulties	_____
__ Diabetes	___ STD's	_____
__ Heart Disease	___ Hyperactivity	_____

Present Health

□ Excellent □ Good □ Fair □ Poor Date of last thorough examination _____

Allergies/Other Issues

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 athletic activity? Yes □ No □ If, yes why? _____

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

Provide details of any illness or medical condition that requires regular treatment or lifestyle alteration: _____

Have you received treatment or counseling for alcohol r drug abuse, eating disorder, depression, or other mental health issue?

Provide details & name of physician. _____

_____

Doctor's Signature

The information provided on this form appears to be an accurate representation of the student's medical history.

_____ _____

Doctor's Signature Date

Medical Examination

Health Services

This portion to be completed by a physician. Please use ballpoint pen.

Full Name:_____ Date of Birth _____

(first) (middle) (last)

Weight : _____ Height: _____ Pulse: _____ Blood Pressure: _____ Temperature: _____

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

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 medical condition? □ Yes □ No

If yes, give reason and extent of restriction: _____

_____

Immunization Record

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

MMR (Measles, Mumps, Rubella)

2 doses are required if born on or after January 1957

Dose 1 (administered at 12-15 months or later)

_____/_____

(month) (year)

Dose 2 (administered at 4-6 years)

_____/_____

(month) (year)

T-dap (combined Tetanus, Diptheria, Pertussis) booster within last 10 years.

_____/_____

(month) (year)

Tuberculin Skin Test (If Required per results of TB Screening Form)

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

_____/_____ Results: □ Negative □ Positive mm induration (horizontal diameter) _____

(month) (year)

2. If PPD is positive, chest x-ray required: _____/_____ x-ray results : □ Normal □ Abnormal

Medical Examination

Health Services

This portion to be completed by a physician. Please use ballpoint pen.

Meningococcal (Quadrivalent Conjugate Vaccine. A,C,Y,W-135)

2 doses required for all college students –first dose given at age 11-12; booster given at age 16. No booster required if first dose given at age 16 or older.

_____/_____ (Dose 1) _____/_____ (Dose 2)

(month) (year))month) (year)

(All students 21 and younger MUST show proof of a meningitis vaccine given on or after their 16th birthday.)

Varicella

History of chicken pox,, a positive varicella antibody, **OR,** 2 doses of vaccine given at least 1 month apart if immunized after age 13.

1. History of chicken pox? □ Yes □ No
2. Immunization:

   Dose 1 Dose 2

   _____/_____ _____/_____

   (month) (year) (month) (year)
3. Varicella Antibody

   _____/_____ Results □ Reactive □ Non-Reactive

   (month) (year)

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

_____/_____ _____/_____ _____/_____

(month) (year) (month) (year) (month) (year)

2. Hepatitis B Surface Antibody

   _____/_____ Results □ Reactive □ Non-Reactive

_____ _____

Physician's Signature Date

_____ _____

Physician's Name (Print Please) Phone Number

_____

Physician's address

TB Screening

If the answer is yes to any of the questions below, BSC requires that you receive TB testing as a part of your medical exams. **If all answers are no**, no further testing action is required.

Tuberculosis (TB) Screening Questionnaire

Full Name:_____ Date of Birth:_____

Please answer the following:

Have you ever had close contact with someone known or suspected to have active TB disease? □ Yes □ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? □ Yes □ No (If yes, please circle the country below)

Have you had frequent or prolonged visits to one or more of the countries listed below with a high prevalence of TB disease.? □ Yes □ No

Have you been a resident and/or employee of high risk congregate settings (e.g., correctional facilities, long term care facilities and homeless shelters)? □ Yes □ No

Have you been a volunteer or health care worker who served clients who are at risk for active TB disease? □ Yes □ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculous infection Or active TB disease—medically underserved, low income, or abusing drugs or alcohol? □ Yes □ No

Afghanistan	Comoros	Iran	Nauru	Singapore
Algeria Cote d'Ivoire	Congo	Iraq	Nepal	Solomon Islands
Angola Democratic People's	Kenya	Kazakhstan	Nicaragua	Somalia
Argentina	Kiribati	Niger	South Sudan	South Africa
Armenia	Republic of Korea	Nigeria	Sri Lanka	Sudan
Azerbaijan	Democratic Republic of Congo	Kuwait	Niue	Suriname
Bahrain	Djibouti	Kyrgyzsran	Pakistan	Swaziland
Bangladesh	Dominican Republic	Lao People's Democratic Republic	Palau	Tajikstan
Belarus	Ecuador	Latvia	Panama	Thailand
Belize	El Salvador	Lesotho	Papua New Guinea	Timor-Leste
Benin	Equatorial Guinea	Liberia	Paraguay	Togo
Bhutan	Eritrea	Libya	Peru	Trinidad and Tobago
Bolivia	Estonia	Lithuania	Philippines	Tunisia
Bosnia & Herzegovina	Ethopia	Madagascar	Poland	Turkey
Botswana	Fiji	Malawi	Portugal	Turkmenistan
Brazil	Gabon	Malaysia	Qatar	Tuvalu
Brunei Darussalam	Gambia	Maldives	Republic of Korea	Uganda
Bulgaria	Georgia	Mali	Republic of Moldova	Ukraine
Burkina Faso	Ghana	Marshall Islands	Romania	United Republic of Tanzania
Burundi	Guatemala	Mauritania	Russian Federation	Uruguay
Cabo Verde	Guinea	Mexico	Rwanda	Uzbekistan
Cambodia	Guinea-Bissau	Micronesia	St Vincent & The Grenadines	Vanuatu
Cameroon	Guyana	Mongolia	Sao Tome & Principe	Venezuela
Central African Republic	Haiti	Morocco	Senegal	Viet Nam
Chad	Honduras	Mozambique	Serbia	Yemen
China	India	Myanmar	Seychelles	Zambia
Colombia	Indonesia	Namibia	Sierra Leone	Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis 2012. Countries with an incident rate of> 20 cases per 100,000 population. For future updates,