HEALTH SERVICES
Student Affairs
SETON HALL UNIVERSITY
Accredited by the ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC.

HEALTH FORM

Seton Hall University Health Services
400 South Orange Avenue, South Orange, New Jersey 07079
Phone (973) 761-9175 • Fax (973) 761-9193
Website: www.shu.edu/health-services.com

Due date:
Fall Semester: August 1
Spring Semester: December 15

Name_____ _____ _____ _____SHU ID#_____ _____
last *first* *middle*

Home Address _____
number and street *city* *state* *zip*

Telephone (___) _____ Date of Birth _____Male__Female__Place of Birth _____ (country)

Semester Entering Seton Hall University_____

EMERGENCY CONTACT: (Name, Relationship and Phone number**)**

_____

PARENT/GUARDIAN CONSENT: (Complete only if student is minor**)**
The law requires that parental permission be obtained for medical evaluation/treatment for minors. The following consent should be signed by parent/guardian so that care can be provided.
I give permission for such diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter/ward.

Student's Name _____

Parent/Guardian Signature _____ Date _____

Relationship _____

PLEASE CHECK: ❑ RESIDENT ❑ COMMUTER ❑ ONLINE

PLEASE CHECK: ❑ UNDERGRADUATE ❑ GRADUATE ❑ LAW

HEALTH INSURANCE INFORMATION

STUDENTS WHO HAVE THEIR OWN INSURANCE:
1) Attach a front/back copy of your card to this form. Carry a copy of your card.
2) Complete the online waiver for exemption from student health insurance (deadlines apply).

STUDENTS ENROLLING IN THE STUDENT HEALTH INSURANCE PLAN:
1) Please refer to www.aetnastudenthealth.com
2) Coverage effective August 15. Cards will be issued after classes begin.

NAME_____**SHU ID#**_____

MEDICAL HISTORY

FAMILY HISTORY

All medical information is strictly confidential.

Age if living, or cause of death:

Father _____ Mother _____ Siblings_____

Check the following diseases that have appeared among **parents and siblings:**

CONDITION	YES	NO	WHO	CONDITION	YES	NO	WHO
High blood pressure				Asthma			
Heart disease				Tuberculosis			
Stroke				Psychological/emotional illness			
Sudden death before age 50				Alcohol/addiction issues			
Diabetes				Other:			
Cancer				Other:			

PERSONAL HISTORY

Do you have allergies to medications? Yes____No___If "yes," please list:_____

Do you have any allergies to latex, food, insects or other allergen? Yes____No_____

Height:_____ **Weight:**_____

(If you answer YES to any of the following questions, please provide details in space provided below.)

High blood pressure?	Y	N	Have you ever been hospitalized?	Y	N
Heart murmur or any disorder of the heart?	Y	N	Have you ever had an operation?	Y	N
Asthma?	Y	N	Do you have a disability (physical or learning)?	Y	N
Hay fever, hives, seasonal allergies?	Y	N	Do you have a history of an eating disorder?	Y	N
Diabetes?	Y	N	Do you have emotional health problems requiring therapy or medications?	Y	N
Thyroid or endocrine disorder?	Y	N	Do you smoke?	Y	N
Reflux, ulcers, colitis or irritable bowel?	Y	N	Do you have a past/present history of substance abuse?	Y	N
Kidney stones or history of kidney disease?	Y	N	Do you have a past/present history of alcohol abuse?	Y	N
Hepatitis?	Y	N	Do you have a past/present history of gambling?	Y	N
Cancer?	Y	N	**List other conditions as needed:**		
Migraine headaches?	Y	N			
Seizure disorder?	Y	N			
Head injury/concussion?	Y	N			
Shingles (herpes zoster)?	Y	N			

Remarks_____

_____

Please list any medications you use on a regular basis. *(Include prescription, over-the-counter, vitamins and supplements.)*

_____

_____

NAME_____**SHU ID#**_____

TUBERCULOSIS RISK QUESTIONNAIRE:

(Student completes)

	YES	NO
Have you ever had a positive reaction to a tuberculosis (PPD) skin test?		
Were you born in one of the countries listed below?		
Within the past five years have spent three or more months in one of the countries listed below?		
Do you have a productive, prolonged cough that has lasted more than three weeks with chest pain, bloody sputum, fever, chills, night sweats, appetite loss, weight loss or tiredness?		
Do you have HIV or other disease that weakens your immune system?		
Have you recently taken immunosuppressive drugs or prednisone (at lease 15mg/day for one month)?		
Are you an employee, volunteer or resident of a high risk setting (hospital, health care setting, nursing home, correctional facility or homeless shelter)?		
Do you have a history of illicit drug use?		

HIGH PREVALENCE COUNTRIES (WORLD HEALTH ORGANIZATION 2006)

Afghanistan	Burundi	Estonia	Kiribati	Mongolia	Portugal	Tanzania-UR
Algeria	Cambodia	Ethiopia	Korea-DPR	Montenegro	Qatar	Thailand
Angola	Cameroon	Fiji	Korea-Republic	Morocco	Romania	Timor-Leste
Anguilla	Cape Verde	Fr. Polynesia	Kuwait	Mozambique	Russian Federation	Togo
Argentina	Central African	Gabon	Kyrgyzstan	Myanmar	Rwanda	Tokelau
Armenia	Rep.	Gambia	Lao PDR	Namibia	St. Vincent &	Tonga
Azerbaijan	Chad	Georgia	Latvia	Nauru	The Grenadines	Tunisia
Bahamas	China (including	Ghana	Lesotho	Nepal	Sao Tome &	Turkey
Bahrain	Taiwan)	Guam	Liberia	New Caledonia	Principe	Turkmenistan
Bangladesh	Colombia	Guatemala	Lithuania	Nicaragua	Saudi Arabia	Tuvalu
Belarus	Comoros	Guinea	Macedonia-TFYR	Niger	Senegal	Uganda
Belize	Congo	Guinea-Bissau	Madagascar	Nigeria	Seychelles	Ukraine
Benin	Congo DR	Guyana	Malawi	Niue	Sierra Leone	Uruguay
Bhutan	Cote d'Ivoire	Haiti	Malaysia	N. Mariana Islands	Singapore	Uzbekistan
Bolivia	Croatia	Honduras	Maldives	Pakistan	Solomon Islands	Vanuatu
Bosnia &	Djibouti	India	Mali	Palau	Somalia	Venezuela
Herzegovina	Dominican Rep	Indonesia	Marshall Islands	Panama	South Africa	Viet Nam
Botswana	Ecuador	Iran	Mauritania	Papua New Guinea	Spain	Wallis&Futuna
Brazil	Egypt	Iraq	Mauritius	Paraguay	Sri Lanka	Islands
Brunei-	El Salvador	Japan	Mexico	Peru	Sudan	W. Bank &
Darussalam	Equatorial-	Kazakhstan	Micronesia	Philippines	Suriname	Gaza Strip
Bulgaria	Guinea	Kenya	Moldova-Rep.	Poland	Syrian Arab	Yemen
Burkina Faso	Eritrea				Republic	Zambia
					Swaziland	Zimbabwe
					Tajikistan	

HEALTH CARE PROVIDER INTERPRETATION GUIDELINE:

>5mm is positive:	**>10 mm is positive:**	**>15 mm is positive:**
-HIV infected persons -a recent contact with TB disease -persons with fibrotic changes on chest x-ray consistent with prior TB -organ transplant recipient -immunosuppressed patients taking >15mg/day of Prednisone for >one month, taking TNF a-antagonist or other immunosuppressive medications	-persons born in high prevalence country or who resided in one for 3 or more months -history of illicit drug use -mycobacteriology laboratory personnel -history of resident, worker, or volunteer in high- risk congregate settings -persons with the following 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	-persons with no known risk factors for TB disease

THIS SECTION MUST BE COMPLETED BY HEALTH CARE PROVIDER

Patient Name _____Date of Birth _____

If you answered yes to any of the questions on the tuberculosis risk questionnaire on previous page, your health care provider must complete this box.

TUBERCULOSIS (PPD) SCREENING: Must be administered **within 6 months** before the first day of class.

Date given:_____ Date read:_____ (Must be 48-72 hours after test) Reaction: _____mm

Result: ☐ Positive (please see interpretation guidelines) ☐ Negative

Positive tests require a chest x-ray (attach radiologist report) Date of x-ray:_____ Result: ☐ Normal ☐ Abnormal

Treatment for LTBI? ☐ Yes ☐ No Medications used:_____ Dates of treatment:_____

Date treatment declined_____

IMMUNIZATION RECORD

REQUIRED:

MEASLES, MUMPS AND RUBELLA: Provide documentation of two doses of vaccine or laboratory proof of immunity.

OR → M.M.R. (Measles, Mumps, Rubella combined)

1. Born before 1957 and therefore considered immune. ❑

2. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ ____ / ____ / ____

3. Dose 2 - Immunized at least one month after Dose 1 _____ ____ / ____ / ____

MEASLES

1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ ____ / ____ / ____

2. Dose 2 - Immunized at least one month after Dose 1 _____ ____ / ____ / ____

RUBELLA

1. Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ ____ / ____ / ____

2. Immunized at least one month after Dose 1 _____ ____ / ____ / ____

MUMPS

1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** _____ ____ / ____ / ____

2. Dose 2 - Immunized at least one month after Dose 1 _____ ____ / ____ /____

HEPATITIS B SERIES (If enrolled for 12 or more credits**)**

(#1) ____ /____ /____ (#2) ____ /____ /____ (#3) ____ / ____ / ____

MENINGITIS (Required for incoming students living on campus. Dose must be within five years of enrollment.**)**

Check one: ❑ Menactra ❑ Menomune ❑Menveo _____ / _____ / _____ Booster _____/_____/_____

TETANUS (Booster within the past ten years): Td _____ / _____ / _____ **OR** Tdap _____ / _____ / _____

RECOMMENDED BUT NOT REQUIRED:

POLIO (Completed primary series of polio immunization): ❑ YES ❑ NO

VARICELLA (CHICKEN POX): Dose #1 _____/_____/_____ Dose #2 _____/_____/_____

HEALTH CARE PROVIDER (please print)

Name/Title_____

Address_____

Signature_____ Date_____ Phone (_____) _____

Provider Stamp Required