A Choice to Change the World

Division of Student Affairs
Department of Student Health Services

Pre Entrance Health Record 2017

Please Complete in Ink or Type Only, Faxes or Copies will not be accepted.

Deadline for Submission

Fall Semester:	**June 1**
Spring Semester:	**December 1**

Return To:

Student Health Services
MacVicar Hall, Box 1683
Spelman College
350 Spelman Lane
Atlanta, Georgia 30314
(404) 270-5249

The Pre-Entrance Health Record is required before you are allowed to move in to campus housing as well as for enrollment at Spelman College. This Pre-Entrance Health Record must be completed honestly and truthfully by you, your parents/guardian and your doctor.

- Failure to provide all pertinent and important medical information could result in denial of request for refrigerators or air conditioned housing unless the student's medical condition specifically requires these items.

- Failure to provide important medical information could result in unnecessary lab tests or screenings a medical condition which has been diagnosed.

- Any and all requests for special accommodations (e.g.), air conditioned housing, refrigerators and other requests for special accommodations must be substantiated with appropriate medical documentation.

- Incomplete pages and responses will result in the booklet being returned to you. Please make copies of this booklet for your records!

Accessibility in Spelman College Residence Halls

- Students with a disability or health concerns that require a specific type of housing assignment may request a reasonable accommodation in Spelman College residence halls.
- Requests are reviewed by the **Committee on Housing & Accessibility**, and are comprised of staff from the Office of the Dean of Students, Counseling & Disability Services, Housing & Residence Life, and Student Health Services.
- The Committee evaluates, among other things, the student's disability status, the necessity of the requested accommodations, potential alternative accommodations, and what, if any, housing accommodations would be appropriate for the student.
- Specific requests for accommodations must be initiated by completing the **Counseling & Disability Services Verification and Request for Accommodation** form. This form may be retrieved online at http://www.spelman.edu/student-life/health-and-wellness/disability-services.
- All medical conditions documented on the Verification Request for Accommodation form must also be fully documented in the appropriate sections of this **Pre-Entrance Health Record** before an accommodation will be considered.
- **Common requests include, but are not limited to:**
  - Accessible housing – residence hall with no or few stairs, and/or elevator access and accessible common areas
  - Private or Semi-private bathroom
  - Private Room
  - Personal Refrigerator
  - Climate Controlled Residence Hall

Please Note: Documentation must explicitly state the rationale for the requested accommodation.
Some requests submitted do not require accommodation under the Americans with Disabilities Act (ADA) and although important for an individual student's comfort, may not be accommodated.

Student Health Insurance

Spelman College requires all degree-seeking students have health insurance or purchase the College sponsored plan. All students are charged for the college sponsored plan up front, however you may elect to waive or opt out of this plan electronically only!

In order to **"opt out of enrollment electronically"** for the college sponsored plan, students and families must provide evidence of current enrollment in a health insurance plan licensed to do business in the United States, with a claims payment office and a U.S. phone number, offers an Annual Maximum comparable to the student health insurance offered by the college.

This coverage includes medical and mental health care, within the Atlanta area that extends beyond **emergency-only** coverage and covers pre-existing conditions as well as prescription drugs.

If you do not wish to purchase the college sponsored plan, you **must opt out or waive the plan by** the deadline of **July 15, for fall enrollment** and **December 15 for spring enrollment if you are a new or transfer student**.

If your request to waive or opt out is declined, you will receive notification through the email address you used to complete the waiver along with instructions to appeal by printing the **"Appeal/Insurance Verification"** form and submitting this to your insurance carrier.

Failure to opt out or waive the college sponsored student health insurance plan will result in this fee being added to the student's account. If you wish to enroll in the college sponsored plan, do nothing, the fees will be added to your account! Submitting copies of family insurance coverage does not satisfy the "opt out enrollment". You must opt out of this plan electronically or insurance fees will be assessed for the year!

PART I
To be completed by Student and Parent
Authorization to Treat and Emergency Contact Information

Clearance to move in to campus housing or registration for classes will not be granted until all Pre-entrance health requirements have been met. Please return this completed form to:
Student Health Services, Spelman College, Box 1683, 350 Spelman Lane, Atlanta, GA 30314

NAME_____
Last **First** **MI**

PERMANENT HOME ADDRESS_____
Street **City**

_____
State **Zip** **Country** **Social Security Number**

HOME PHONE NUMBER _____ **CELL PHONE**_____

E-MAIL ADDRESS_____

DATE OF BIRTH_____ **AGE**_____ **Spelman ID#**_____

ENROLLMENT DATE (Semester/Year) FALL/_____**(Semester/Year)** Spring/_____

ENROLLMENT CLASSIFICATION: ☐**Regular F/T** ☐ **Regular P/T** ☐ **International** ☐ **Transfer**
☐ **Pauline E. Drake Scholars** ☐**Guest**
☐ **Exchange/International** ☐**Exchange-Domestic**

AUTHORIZATIONS: **(Parent or legal guardian MUST sign if under 18 years of age)** I hereby accept financial responsibility for the expense of health care services and I authorize the medical providers of Spelman College Student Health Services and their agents or consultants, including emergency medical technicians, area hospitals or other treatment facilities, to perform diagnostic and treatment procedures, on the above named student, which in their judgment may become necessary while she attends Spelman College. I have no expectation for Spelman College to pay medical expenses for the student should she need treatment outside of Student Health Services. I agree to absolve and hold harmless Spelman College in making medical decisions for the student. I understand that every effort will be made to notify the parent or legal guardian once permission is obtained from the student in the event of a major illness or injury. I understand that the parent or guardian may not necessarily receive notification prior to treatment.

Students Signature_____Date_____

Parent/Guardian
Signature_____Date_____

EMERGENCY CONTACT PERSON:

NAME_____RELATIONSHIP_____

ADDRESS_____

DAY TIME PHONE NUMBER ( ) _____NIGHT TIME PHONE NUMBER ( ) _____

[TO BE COMPLETED BY STUDENT HEALTH SERVICES PERSONNEL]

Status: **Complete** ☐ Reviewed By: _____Date_____

Incomplete ☐ Checklist Indicating Missing Information Sent 1st Date Returned _____ 2nd Date returned_____

PART II

MEDICAL HISTORY AND DOCUMENTATION OF NEED FOR SPECIAL ACCOMODATION
MUST BE COMPLETED BY THE MEDICAL PROVIDER

Name of Student: _____

This form must be completed and signed by your health care provider based on an examination date no earlier than August 1, 2016. ***All ITEMS ARE REQUIRED!!***

DRUG ALLERGIES: ☐ Yes ☐ No, if yes to what? ☐ PCN ☐ Sulfa ☐ Erythromycin ☐ other_____

If yes, what is the nature of the reaction? _____

FOOD ALLERGIES: ☐ Yes ☐ No, if yes to what? _____

If yes, what is the nature of the reaction? _____

Blood Pressure_____ Pulse_____ Height _____Weight_____ BMI_____

Specific requests for accommodations must be initiated by completing the **Counseling & Disability Services Verification and Request for Accommodation** form. This form may be retrieved online at http://www.spelman.edu/student-life/health-and-wellness/disability-services. All medical conditions documented on the Verification Request for Accommodation form must also be fully documented in the appropriate sections of this **Pre-Entrance Health Record** before an accommodation will be considered.

Please list all prescription and nonprescription medications as well as dosages this student currently takes_____

_____

Is this student receiving treatment or care for any acute or chronic medical condition? ☐Yes ☐ No If yes, please explain

_____

Does this student require special accommodations because of any chronic medical condition? ☐Yes ☐ No if yes, what is the medical condition and the special accommodations required

_____

Is this student receiving therapy for any emotional or psychiatric condition? ☐Yes ☐ No If yes, please explain _____

_____

Does this individual require special accommodations because of the emotional or psychiatric condition? ☐Yes ☐ No if yes, what accommodations are required?

_____

_____

Name of Student: _____

Has this individual had any surgical procedures? ☐Yes ☐ No If yes, please explain

_____

Are there any learning disabilities or learning challenges that require medication for management? ☐Yes ☐ No If yes, please explain indicating medication, dosage and frequency

_____

_____

Does the student have food issues requiring special diet? ☐Yes ☐ No If yes, please explain the nature of the food issue and specific diet required

_____

_____

May the student participate in an athletic, sports or college wellness program? ☐Yes ☐ No If no, please explain?

_____

(Required – May not be signed by a family member)

M.D./D.O./N.P./P.A.'s Name (please print) _____

Signature_____

Address_____

Date of Exam_____Telephone number ( ) _____

Name _____

Last First Date of Birth

PART III
REQUIRED IMMUNIZATIONS AND TESTS

Georgia's law and/or Spelman College require the following immunizations or tests for *all* entering students. You will not be able to register for classes until this information has been provided. You must include the month, day and year, and this form must be signed and dated by an M.D., N.P., D.O., P.A.

MONTH/DAY/YEAR

MENACTRA VACCINE **(Required)** _____/_____/_____

VARICELLA VACCINE 1st vaccine _____/_____/_____
(2 doses required) 2nd vaccine _____/_____/_____
OR
OTHER IMMUNITY: Student had chickenpox disease _____/_____/_____
OR
Laboratory/serology test for evidence of immunity _____/_____/_____
Note: if the test is NON-REACTIVE, You MUST receive the Varicella vaccines ☐ **Reactive** ☐**Non-Reactive**

HEPATITIS VACCINE 1st vaccine _____/_____/_____
(3 doses required) 2nd vaccine _____/_____/_____
OR 3rd vaccine _____/_____/_____
Other Means of Obtaining Proof of Immunity
Laboratory/serology test for Hepatitis B surface antigen antibody: _____/_____/_____
Obtain if uncertain about dates of your Hepatitis B vaccines ☐**Reactive** ☐ **Non-Reactive**
Note: if the test is NON-REACTIVE, you must receive the Hepatitis B vaccines.

M.M.R (MEASLES, MUMPS AND RUBELLA) 1st vaccine _____/_____/_____
(2 doses required) 2nd vaccine _____/_____/_____
OR
Student born before 1957 is considered immune. <Date of Birth> _____/_____/_____
Other Means of Obtaining Proof of Immunity
Laboratory/serology test for evidence of immunity: _____/_____/_____
☐**Reactive** ☐ **Non-Reactive**
Obtain if uncertain about dates of vaccine or disease
Note: if the test is NON-REACTIVE, You MUST receive the MMR vaccines.
TETANUS, DIPHTHERIA (Tdap) or (Td) _____/_____/_____
Within the last 10 years

The following vaccines are not required. Please document if you have received them:

Other Immunizations	Date Dose #1	Date Dose #2	Date Dose #3	Date Dose #4 or Booster
Meningitis B - Trumenba				
Meningitis B - Bexsero				
Hepatitis A				
HPV*				
Typhoid (injectable)—most recent				
Typhoid (oral)—most recent completed				
Japanese Encephalitis (Ixiaro)				
Yellow Fever				
Rabies				
Other (i.e., Flu)				

*HPV vaccine is recommended for all students

M.D./D.O./N.P./P.A. Signature **Date** **(Required—May not be signed by a family member)**

Name_____ Date of Birth_____

Last First MI MM/DD/YYYY

A. Tuberculosis (TB) screening Questionnaire (to be completed by incoming students)

Please answer the following:

Have you ever had a positive tuberculosis (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 will you be arriving or did you arrive in the U.S. within the past five years? (If yes, please circle the country.) ☐ Yes ☐ No

Have you ever traveled for more than two weeks to/in one or more of the countries listed below? (If yes, please CHECK the country/ies and list dates of travel.) ☐ Yes ☐ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo (Democratic Republic)
Congo (Republic)
Côte d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Rep. of)
Iraq
Kazakhstan
Kenya
Kiribati
Korea, DPR
Korea, Republic of
Kuwait
Kyrgyzstan
Laos (People's Democratic Republic)
Latvia Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Island
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Moldova, Republic of
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
São Tomé & Príncipe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Tanzania, United Rep. of
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Vietnam
Yemen
Zambia
Zimbabwe

Have you had frequent or prolonged visits to one or more of the countries listed above with a high prevalence of TB disease? If yes, CIRCLE the countries above!

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 increased risk for active TB disease? ☐ Yes ☐ No

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

_____ _____

Student Signature **Date** (MM/DD/YYYY) **M.D./D.O./N.P./P.A. Signature Required** **Date** (MM/DD/YYYY)

May not be signed by a family member

Name_____ Date of Birth_____
Last First MI MM/DD/YYYY

If the answer is YES to any of the above questions, Spelman College requires that you receive TB testing soon as possible but at least prior to the start of the subsequent semester.

B. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering Yes to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) ☐ Yes ☐ No
History of BCG vaccination? (If yes, consider IGRA if possible.) ☐ Yes ☐ No

1. TB Symptom Check
   Does the student have signs or symptoms of active pulmonary tuberculosis disease? ☐ Yes ☐ No
   If no, proceed to 2 or 3, If yes, check below:
   - ☐ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
   - ☐ Coughing up blood (hemoptysis)
   - ☐ Chest Pain
   - ☐ Loss of appetite
   - ☐ Unexplained weight loss
   - ☐ Night sweats
   - ☐ Fever

Process 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: ___/____/____ Date Read: ____/____/_____ Result: _____mm of induration
mm/dd/yy mm/dd/yy *Interpretation: positive ☐ negative ☐

3. Chest x-ray: (Required if IGRA is positive or if skin test is positive).

Date of Chest-x-ray ___/___/___ Results: normal ☐ abnormal ☐

Risk Factor	Positive Result
Close contact with an individual with infectious tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for one month or more in a country that has a high rate of tuberculosis	10 mm or more
None (test not recommended)	15 mm or more

M.D./D.O./N.P./P.A. Signature Required **Date**
(Required- May not be signed by a family member) MM/DD/YY