

# SCHOOL OF HEALTH & MEDICAL SCIENCES HEALTH FORM



Dear Student,

THE STATE OF NEW JERSEY REQUIRES STUDENTS TO PROVIDE BASIC HEALTH INFORMATION TO THEIR INSTITUTION PRIOR TO MATRICULATION. THE SCHOOL OF HEALTH & MEDICAL SCIENCES' CLINICAL PRACTICE FACILITIES ALSO HAVE HEALTH REQUIREMENTS WITH WHICH YOU MUST COMPLY. THE FOLLOWING PROGRAMS ARE INCLUDED: PHYSICIAN ASSISTANT, ATHLETIC TRAINING, SPEECH-LANGUAGE PATHOLOGY, PHYSICAL THERAPY, AND OCCUPATIONAL THERAPY. FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN YOUR NOT BEING ABLE TO REGISTER FOR CLASSES AND/OR PARTICIPATE IN CLINICAL PRACTICE. PLEASE ATTACH ALL COPIES OF LABORATORY TESTS AND UPDATE THE REQUIRED IMMUNIZATIONS. CLINICAL SITES MAY REQUIRE ADDITIONAL HEALTH DOCUMENTATION.

**Completed forms must be submitted by July 1 to:**

Seton Hall University Health Services  
Immunization Coordinator  
400 South Orange Avenue, South Orange, New Jersey 07079

*Should you have any questions, please contact Health Services between the hours of 9 a.m. and 4:45 p.m. (Monday – Friday)*

Phone (973) 761-9175 • Fax (973) 761-9193  
Health Services Location: 303 Centre Street

**PART A** *Please print or type.*

Name \_\_\_\_\_ SHU ID \_\_\_\_\_  
*last first middle*

Home Address \_\_\_\_\_  
*number and street city county state zip*

Telephone (\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Place of Birth \_\_\_\_\_ U.S. Citizen  Yes  No

Name, Address and Phone Number of Nearest Kin (such as parent or guardian) \_\_\_\_\_  
\_\_\_\_\_

Insurance Carrier and Policy Number \_\_\_\_\_

If HMO, please provide the following:

Primary Care Physician and Hospital \_\_\_\_\_

**RELEASE OF INFORMATION**

The information you provide to us is confidential. It may be necessary to communicate information that relates only to your program to the Directors of Clinical Education. In order to communicate this information, please sign below.

I give permission to Health Services staff to communicate health information pertinent only to my program to the Directors of Clinical Education.

Student Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**PROGRAM** (*check one*):  AT  OT  PA  PT  SLP

## FAMILY HISTORY

Age and health, if living, or cause of death:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

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

Tuberculosis \_\_\_\_\_  Kidney disease \_\_\_\_\_

Diabetes \_\_\_\_\_  Emotional illness \_\_\_\_\_

Cancer (type) \_\_\_\_\_  High blood pressure \_\_\_\_\_

Seizure disorder \_\_\_\_\_  Alcohol/drug abuse \_\_\_\_\_

Stroke \_\_\_\_\_  Asthma \_\_\_\_\_

Heart disease \_\_\_\_\_  Other \_\_\_\_\_

## PERSONAL HISTORY

All medical information is strictly confidential. **(Please provide details of all positive answers under remarks.)**

	YES	NO		YES	NO
Any history of reaction to medication, latex, food and/or serum? ( <i>Specify reaction under remarks.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>
Serious reaction to insect bites	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual cycle disorder	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever, hives, seasonal allergies	<input type="checkbox"/>	<input type="checkbox"/>	Disabling loss of vision, hearing	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<i>(Please note quantity under remarks.)</i>		
Heart murmur or any disorder of the heart	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced a problem with drug or alcohol use?	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever experienced a severe dietary problem (anorexia, bulimia, obesity)?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid or endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious head injury, illness, hospitalization or operation?	<input type="checkbox"/>	<input type="checkbox"/>
Colitis, irritable bowel or Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>
Shingles (Herpes Zoster)	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney stones or history of kidney disease	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			

**If you have ever had a need for personal counseling, please contact SHU Counseling Services. Counseling Services offers free and confidential psychological services. For more information, call (973) 761-9500 or visit: <http://studentaffairs.shu.edu/counseling>.**

Remarks: \_\_\_\_\_

Please list any medications you use on a regular basis. (*Include amount and usage per day.*) \_\_\_\_\_

# IMMUNIZATION HISTORY

\*PLEASE NOTE BOTH PAGES 3, 4 AND 5 ARE TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER.

- A.  TETANUS DIPHTHERIA (Td) Month/Day/Year  
 TETANUS DIPHTHERIA ACELLULAR PERTUSSIS (Tdap)  
1. Completed primary series of Diphtheria, Pertussis, Tetanus immunization ..... \_\_\_ / \_\_\_ / \_\_\_  
2. Received most recent booster **WITHIN THE LAST TEN YEARS** ..... \_\_\_ / \_\_\_ / \_\_\_

- B. 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 ..... \_\_\_ / \_\_\_ / \_\_\_

- C. MEASLES  
1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** ..... \_\_\_ / \_\_\_ / \_\_\_  
2. Dose 2 - Immunized at least one month after Dose 1 ..... \_\_\_ / \_\_\_ / \_\_\_

- D. RUBELLA  
1. Immunized **ON OR AFTER THE FIRST BIRTHDAY** ..... \_\_\_ / \_\_\_ / \_\_\_  
2. Immunized at least one month after Dose 1..... \_\_\_ / \_\_\_ / \_\_\_

- E. MUMPS  
1. Dose 1 - Immunized **ON OR AFTER THE FIRST BIRTHDAY** ..... \_\_\_ / \_\_\_ / \_\_\_  
2. Dose 2 - Immunized at least one month after Dose 1 ..... \_\_\_ / \_\_\_ / \_\_\_

**B. through E.:** If documentation of vaccine is unavailable, an immune titre blood test is required (please include a copy of results). If the titre does not indicate immunity, vaccines are required.

**ALL OT AND PT STUDENTS MUST HAVE MMR TITRE (INCLUDE DATE AND COPY).**

- F. POLIO  
1. Completed primary series of polio immunization  Yes  No

- G. MENINGITIS - (REQUIRED FOR INCOMING RESIDENTIAL STUDENTS). ANY STUDENT WHO WISHES TO REDUCE HIS OR HER RISK OF DISEASE CAN CONSIDER THE VACCINE.  
1. Check one:  Menactra  Menomune..... \_\_\_ / \_\_\_ / \_\_\_  
(PLEASE READ INFORMATION ON MENINGITIS @ [HTTP://STUDENTAFFAIRS.SHU.EDU/HEALTH/](http://STUDENTAFFAIRS.SHU.EDU/HEALTH/))

- H. HEPATITIS B SERIES  
THE STATE OF NJ REQUIRES THREE HEPATITIS B VACCINES IF ENROLLED FOR 12 OR MORE CREDITS, REGARDLESS OF AGE . To start clinical placement, you must have received two of the three vaccines.

(#1) \_\_\_ / \_\_\_ / \_\_\_                      (#2) \_\_\_ / \_\_\_ / \_\_\_                      (#3) \_\_\_ / \_\_\_ / \_\_\_

- I. VARICELLA TITRE (REQUIRED) :  
1. Provide date and copy of the laboratory test ..... \_\_\_ / \_\_\_ / \_\_\_  
2. If not immune: Varicella vaccines are recommended:                      (#1) \_\_\_ / \_\_\_ / \_\_\_                      (#2) \_\_\_ / \_\_\_ / \_\_\_

**J. TUBERCULOSIS (COMPLETE ALL THAT APPLY)**

PPDs are required unless student provides documentation of previous positive PPD. A Tine or Monovac is not acceptable. PPDs MUST be read within 48 to 72 hours by an R.N., N.P. or M.D. A negative PPD result < 12 months prior to entering the program is acceptable.

- 1. Please note, if you:
  - A. Have never had a PPD
  - B. Had a negative PPD result > 12 months before entering the program
  - C. Had an undocumented positive PPD result
  - D. Had a previous BCG vaccination

You are required to receive the two-step PPD process. Give date and results:

(#1) Results: Size of induration \_\_\_\_\_ Applied \_\_\_ / \_\_\_ / \_\_\_ Read \_\_\_ / \_\_\_ / \_\_\_

(#2) Results: Size of induration \_\_\_\_\_ Applied (At least 3 weeks after PPD #1) \_\_\_ / \_\_\_ / \_\_\_ Read \_\_\_ / \_\_\_ / \_\_\_

2. Positive PPD: Size of induration \_\_\_\_\_ mm

**Anyone with a history of a positive PPD must enclose copies of pertinent medical records.**

Chest x-ray required within one year of entry with positive or history of positive PPD.

Give date and result of chest x-ray ..... \_\_\_ / \_\_\_ / \_\_\_

Result:  Positive  Negative

3. Date of completion of six months to one year of Isoniazid therapy ..... \_\_\_ / \_\_\_ / \_\_\_

4. Had BCG vaccine administered ..... \_\_\_ / \_\_\_ / \_\_\_

**(PPDs still required unless student provides documentation of previous positive PPD)**

**TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER (M.D., N.P., P.A., D.O.)**

(Physical exam to be performed within one year prior to entry into the University)

Patient Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

Any history of reaction to medication, latex, food and/or serum?  Yes  No

Explain \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp \_\_\_\_\_

Vision: *uncorrected* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ ; *with glasses/contacts* Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_

Hearing: RIGHT normal  Yes  No LEFT normal  Yes  No

Impairment \_\_\_\_\_

Laboratory Tests: (attach copies) #1 Urinalysis #2 CBC #3 Electrocardiogram recommended for men > 45 yr, women > 55 yr

No.	System	Satisfactory	Unsatisfactory	Describe Abnormality
1	Skin, lymphatics			
2	Eyes			
3	Ears			
4	Nose, throat			
5	Neck, thyroid			
6	Chest, breasts, lungs			
7	Heart			
8	Abdomen, liver, kidneys, spleen			
9	Hernia			
10	Genitalia			
11	Pelvic (if indicated)			
12	Rectal			
13	Extremities, back, spine			
14	Joints			
15	Neurological			
16	Psychological			

The following abnormalities should be noted: \_\_\_\_\_

The applicant  does  does not have a history of emotional, psychological or psychiatric disturbance.

Applicant may participate in GME CLINICAL PRACTICUM:

without restriction

with the following restrictions: \_\_\_\_\_

Applicant should not participate in sports. Reason for limiting activity: \_\_\_\_\_

**HEALTH CARE PROVIDER** *(Please print.)*

Name \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_