PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE COMPLETING THE FORMS

PARENTS/STUDENTS: The Health Form (pgs 3 - 9) must be completed, returned, and verified by the University Wellness Center Health Service personnel by July 15th. The health form must be complete or you must have a plan in place with Health Service personnel to complete your forms before you will be allowed to move into your residential hall.

All portions of the health form must be scanned and uploaded in PDF format via the link provided on the University Health Form checklist item found on the student’s Applicant Status Page. Students may also fax their information to 833-642-0898. Students should check the status of their health form via their Applicant Status Page. If a health form is received incomplete or missing a required component, the student will be notified via their Sewanee Email of the missing/incomplete component. Students who have questions regarding the health form should contact the Wellness Center at the phone number listed below or email healthforms@sewanee.edu

CONTACT INFORMATION: (Phone): 931-598-1777

MAILING: University Wellness Center
    University Health Service
    SPO 1182
    Sewanee, TN 37383

HEALTH FORM (Pgs 3 - 9)
All new students, including transfer students, must complete the Health Form and all required immunizations. Legal safeguards make it necessary for each student to have a physical examination, immunization record, and medical history on file with the University Wellness Center. The primary purpose of this medical record is to provide a basic point of reference in case of future illness, to identify any medical condition requiring attention before it interferes with your studies, and to provide the University Wellness Center staff with knowledge of any need for ongoing treatment. The University Wellness Center is bound by HIPAA and all information will be strictly confidential.

INSURANCE
It is recommended that all students have adequate health insurance that will provide coverage while in the Sewanee area. It is the responsibility of the student and/or parent to ensure that there are no restrictions or limitations with your insurance coverage should medical care be necessary. Please contact your insurance carrier to verify and discuss your coverage prior to arrival on campus.

REQUIRED IMMUNIZATIONS
The University requires all students to have certain immunizations on file in order to protect our campus community. Some immunizations are required within a specified time frame (Tdap, MCV4). Please have a conversation with your healthcare provider to ensure you have all required vaccines necessary to complete your health form and that they were administered within the appropriate time frame.
RECOMMENDED VACCINES, COVID-19 INFORMATION AND SERVICES OFFERED AT HEALTH SERVICE
Please visit the University’s website to see a list of recommended vaccines and services offered at the University Health Service. We strongly encourage parents and students to review the recommended vaccines with their provider. Students who plan to travel are encouraged to get the Covid-19 vaccine, Hepatitis A vaccine and influenza vaccine. We also encourage parents and students to review the University’s website regarding Covid-19 information.


CONSENT TO TREAT (Pg 8):
All students **under the age of 18** must have a legal parent or guardian sign page 8 (Consent for Treatment of Minor).

INTERNATIONAL STUDENTS ONLY:
Immunizations – If you have any required immunizations that are not available in your country, please email healthforms@sewanee.edu to discuss your immunization status.

Insurance – Please check the box if you are obtaining International University Coverage and/or other private insurance. You do not need to complete and/or attach a copy of your insurance at this time as we understand you may not have access to your coverage information until you arrive on campus.

ATHLETES:
Please note that the University Wellness Center and the University Athletic Department are two separate facilities and require different health forms. Please make sure you submit the correct health form to the appropriate department.

ACCESSIBILITY ACCOMMODATIONS:
If you are in need of Academic Accommodations, Temporary Condition Accommodations, Physical Disability Accommodations, or Chronic Health Accommodations, please contact Student Accessibility Services at 931-598-1178 for assistance.

THE UNIVERSITY WELLNESS CENTER IS HIPAA COMPLIANT (Information regarding HIPAA can be found at www.hhs.gov/ocr/privacy/).
MEDICAL RECORD:

Student’s Name: ___________________  Nickname: _____________________________  Gender: ___________

Date of Birth: ________________________  SSN: _______________________________  Student’s Cell Phone Number: _________________

Mailing Address: _____________________________________________ City: __________________________ State/Zip: __________________

Parent/Guardian Name and Cell Number: ____________________________________________      (_______)_______________________________

Parent/Guardian Name and Cell Number: ____________________________________________      (_______)_______________________________

INSURANCE
All students are required to have adequate health insurance that will provide coverage while in the Sewanee area. It is the responsibility of the student and/or parent to ensure that there are no restrictions or limitations with your insurance coverage should medical care be necessary.

PLEASE BE ADVISED THAT HMO/MANAGED CARE PLANS, KAISER, AND STATE MEDICAID PLANS WILL NOT PROVIDE COVERAGE IN THE SEWANEE AREA

HEALTH INSURANCE: __________________________________________

NAME & ADDRESS OF INSURANCE COMPANY

_______________________________ ____________________________

Policy Holders DOB & SSN  Employer

Name of Policy Holder

Policy ID/Certificate Number

Group Number

□  HMO   □  PPO

(Required Information)

** A CLEAR COPY OF BOTH THE FRONT AND BACK OF THE INSURANCE CARD MUST BE SUBMITTED WITH FORMS **

□  I have attached a copy of the front and back of my insurance card

INTERNATIONAL STUDENTS ONLY:

□  Obtaining International University Student Insurance Coverage and/or Other Coverage

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES
I hereby authorize the staff of the University Wellness Center, their agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while the student is enrolled at the University of the South. I understand that Wellness Center professionals will have access to patient records, as deemed necessary, to facilitate and implement effective treatment.

Student Signature: ____________________________________________  Date (mm/dd/yr): __________________

Parent/Guardian Signature: ____________________________________________  Date (mm/dd/yr): __________________
**THIS PAGE TO BE COMPLETED BY STUDENT. PLEASE TAKE THIS WITH YOU WHEN Completing YOUR PHYSICAL WITH YOUR PHYSICIAN **

Student’s Name: ___________________________ Date of Birth: ___________ Last 4 of SSN: ___________

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>AGE</th>
<th>OCCUPATION</th>
<th>STATE OF HEALTH/CHRONIC ILLNESSES</th>
<th>IF DECEASED, AGE AT DEATH</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENT/GUARDIAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARENT/GUARDIAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SIBLINGS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List immediate family history of any disease, such as diabetes, hypertension, migraines, thyroid disorder, heart disease, cancer, etc., and family member’s relationship to you: ___________________________

**HEALTH HISTORY**

If you have ever had any of the following conditions or symptoms, please place a check mark in the appropriate box.

<table>
<thead>
<tr>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal Pap Smear</td>
</tr>
<tr>
<td>ADD/ADHD</td>
</tr>
<tr>
<td>Anemia/Blood Disorder</td>
</tr>
<tr>
<td>Arthritis</td>
</tr>
<tr>
<td>Asthma/Inhaler Use</td>
</tr>
<tr>
<td>Back Pain</td>
</tr>
<tr>
<td>Bone/Joint Disorder</td>
</tr>
<tr>
<td>Breast Mass</td>
</tr>
<tr>
<td>Cancer</td>
</tr>
<tr>
<td>Cardiac</td>
</tr>
<tr>
<td>Chemotherapy/Radiation</td>
</tr>
<tr>
<td>Chest Pain</td>
</tr>
</tbody>
</table>

Explain conditions checked and any other conditions not listed

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

Are you currently taking any medications including hormonal therapy? _____ Yes _____ No If so, list name and dosage: ________________________________

________________________________________________________________________________________

Do you have any drug allergies? _____ Yes _____ No If so, name the drug and what type of reaction you have with the medication:

________________________________________________________________________________________

Do you have any other allergies? _____ Yes _____ No If so, explain:

________________________________________________________________________________________

Have you ever been admitted to the hospital and if so, please give date and reason for admission:

________________________________________________________________________________________

Do you have any physical challenges or conditions that may impact your activity? _____ Yes _____ No If so, explain:

________________________________________________________________________________________

**MENTAL HEALTH HISTORY**

Have you received psychological/psychiatric treatment (e.g., anxiety, depression, ADHD, etc)? _____ Yes _____ No If yes, explain:

________________________________________________________________________________________

Please list current/past medication(s) used for psychological/psychiatric treatment and the dosing amount:

________________________________________________________________________________________

________________________________________________________________________________________

By whom were you treated?

Name, Address and Contact Number for Mental Health Provider

________________________________________________________________________________________

Have you ever been treated for an eating disorder? _____ Yes _____ No If so, please explain:

________________________________________________________________________________________

________________________________________________________________________________________

If provider of eating disorder was different than mental health provider, please list (Name, Address and Contact Number for Provider):

________________________________________________________________________________________

Name, Address and Contact Number for Provider
HEALTH CARE PROVIDER’S REPORT OF PHYSICAL EXAMINATION – REQUIRED FOR ALL STUDENTS

To the examining health care provider: Please review the student’s medical history (page 4 of this form) and complete the provider’s form below, as well as the student’s immunization record. Please comment on all positive answers. This student has been accepted to the University of the South – the information supplied will not affect his/her status; it will be used in the service of providing health care, if necessary. This information is strictly for use of the University Wellness Center and will not be released without student consent.

**Physicals must be within a year and Physicals completed by a physician who is a family relative will not be accepted**

<table>
<thead>
<tr>
<th>Student’s Name: __________________________________________</th>
<th>Date of Birth: __________________</th>
<th>Date of Exam: __________________</th>
</tr>
</thead>
</table>

HEIGHT: __________  WEIGHT: __________  BMI: __________  B/P: __________  PULSE: __________  TEMP: __________  RESP: __________

VISUAL ACUITY: (Corrected R 20/____  L 20/____)  (Uncorrected R 20/____  L 20/____)  Glasses / Contacts / Both

<table>
<thead>
<tr>
<th>Ears, Nose, and Throat</th>
<th>WNL</th>
<th>ABN</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head and Neck</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest and Lungs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia / Hernia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Date of last Gyn Exam-if applicable)

Orthopedic Screening

<table>
<thead>
<tr>
<th>a. Neck</th>
<th>WNL</th>
<th>ABN</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. Spine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Shoulders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Arms &amp; Hands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Hips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Knees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Legs &amp; Feet</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How long have you known this student?

Has this student been treated for any significant disease or medical condition other than minor short term illness?  Y / N  If yes, explain: ________________________________

Taking into consideration the student’s health history (see page 3) and physical examination, is there any reason to restrict/prohibit/limit - walking, exercising, or participation in sports?  Y / N  Explain:

Is this student capable of managing college academics?  Y / N - Physically  Y / N - Mentally  Y / N - Developmentally  Y / N - Socially  If no, explain:

Is this student currently under your care and/or taking medication?  Y / N  If yes, explain:

Does this student have any drug and/or food allergies?  Y / N  If yes, please list:

Is the student on a special diet or have dietary restrictions?  Y / N  Explain:

Does this student have a history of an eating disorder, cardiac problems, or attention deficit hyperactivity disorder?  Y / N  If yes, please provide a status report/plan of care from the treating physician and/or treating therapist.  (Comments):

Signature of examining health care provider: ___________________________  Date: __________________

Phone: (______) ___________________________  Fax: (______) ___________________________

Address: ____________________________________________________________

City: ____________________________________  State: __________________  Zip: __________________
HEALTH CARE PROVIDER’S REPORT OF IMMUNIZATIONS
IMMUNIZATIONS MUST BE COMPLETED AND SUBMITTED ON THIS FORM. Immunizations not submitted on this form may cause a delay in review and processing. Students who do not have the REQUIRED IMMUNIZATIONS completed and submitted by July 15th will be dropped from enrollment in the fall.

Student’s Name: __________________________________________ Date of Birth: ______________________ Last 4 of SSN: _____________

**REQUIRED IMMUNIZATIONS and TUBERCULOSIS SCREENING**

Meningococcal (A, C, Y, W-135) / MCV4 – One dose required after the sixteenth birthday.
1. Menactra/Menveo ____/____/____ (MUST BE AFTER AGE 16)

MMR (measles, mumps, rubella) – two doses are required or proof of positive antibody titer.
1. Dose 1 (at age 12 mos. or later) ____/____/____
2. Dose 2 (at least 28 days after 1st dose) ____/____/____

Tetanus, diphtheria, pertussis – tetanus/diphtheria/pertussis (Tdap) is required within the last 10 years. Tetanus/diphtheria (Td) is not sufficient. Tdap booster recommended for ages 11 – 64 unless contraindicated. **If Tdap will expire in the next 3 years please boost.**
1. Tdap ____/____/____

Hepatitis B – three doses of Hepatitis B are required or proof of positive antibody titer.
1. Dose (1) ____/____/____ (2) ____/____/____ (3) ____/____/____

Polio – if all dates of primary series not known, three primary series are required.
1. IPV and/or OPV (1) ____/____/____ (2) ____/____/____ (3) ____/____/____ (4) ____/____/____ (5) ____/____/____

Varicella – two doses are required or proof of positive antibody titer.
1. Varicella Immunizations: (1) ____/____/____ (2) ____/____/____

**All titer results must be attached to this form. If a Titer is non-reactive, the patient must receive the appropriate immunizations to meet university requirements **

Tuberculosis (TB) Screening Questionnaire (See page 7 and 8)
The Questionnaire must be completed by all students. If you answer YES to any of the questions on page 7, your healthcare provider will need to complete page 8 of the health form.

Recommended Immunizations

Covid 19 – (Moderna or Pfizer or Johnson & Johnson) – **Circle One**
1. Dose (1) ____/____/____ (2) ____/____/____

Meningococcal B (Bexsero or Trumenba) – **Circle One**
Dose (1) ____/____/____ (2) ____/____/____

Hepatitis A – two doses of Hepatitis A
1. Dose (1) ____/____/____ (2) ____/____/____

(HPV) Gardasil – two and/or three doses of HPV 9
Dose (1) ____/____/____ (2) ____/____/____ (3) ____/____/____

For vaccines with different names/manufacturers, please circle which vaccine was administered so that we can properly document and administer additional vaccine boosters if needed.

Signature of health care provider: __________________________________________________________________________________________

Phone: (________) __________________________________________ Fax: (________) ____________________________________________

Address: _________________________________________________________________________________________________________

City: _____________________________________________________ State: ________________________ Zip: ____________________________
PART I: Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease?  ___ Yes  ___ No

2. 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)

   Afghanistan  Cote d’Ivoire  Kenya  Nicaragua
   Algeria  Democratic People’s  Kiribati  Niger
   Angola  Republic of Korea  Kuwait  Nigeria
   Argentina  Democratic Republic of  Kyrgyzstan  Nine
   Armenia  the Congo  Lao People’s  Pakistan
   Azerbaijan  Djibouti  Democratic Republic  Palau
   Bahrain  Dominican Republic  Latvia  Panama
   Bangladesh  Ecuador  Lesotho  Papua New Guinea
   Belarus  El Salvador  Liberia  Paraguay
   Belize  Equatorial Guinea  Libya  Peru
   Benin  Eritrea  Lithuania  Philippines
   Bhutan  Estonia  Madagascar  Poland
   Bolivia (Plurinational State of)  Ethiopia  Malawi  Portugal
   Bosnia & Herzegovina  Fiji  Malaysia  Qatar
   Botswana  Gabon  Maldives  Republic of Korea
   Brazil  Gambia  Mali  Republic of Moldova
   Brunei Darussalam  Georgia  Marshall Islands  Romania
   Bulgaria  Ghana  Mauritania  Russian Federation
   Burkina Faso  Guatemala  Mauritius  Rwanda
   Burundi  Guinea  Mexico  St. Vincent & the Grenadines
   Cabo Verde  Guinea-Bissau  Micronesia (Federated States of)
   Cambodia  Guyana  Mongolia  Sao Tomo & Principe
   Cameroon  Haiti  Mozambique  Seychelles
   Central African Republic  Honduras  Morocco  Serbia
   Chad  India  Namibia  Singapore
   China  Indonesia  Myanmar  Sierra Leone
   Colombia  Iran (Islamic Republic of)  Namibia  Singapore
   Comoros  Iraq  Nauru  Solomon Islands
   Congo  Kazakhstan  Nepal  Somalia
   South Africa  Sudan  Suriname  Swaziland
   Sri Lanka  Taiwan  Togo  Trinidad
   Sudan  Tajikistan  Uganda  Tunisia
   Swaziland  Ukraine  Togo
   Taiwan  United Republic of Tanzania  Turkey
   Turkmenistan  Tuvalu
   Uganda  Turkey  Ukraine
   Turkey  United Republic of
   U.S. (Federal Territory)  United States of America
   Uzbekistan  Vanuatu  Veneuela (Bolvarian
   Republic of)
   Vanuatu  Veneuela (Bolvarian Republic of)
   Veneuela (Bolvarian Republic of)
   VietNam  Yemen
   Yemen  Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

3. 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, CHECK the countries, above)  ___ Yes  ___ No

4. 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

5. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?  ___ Yes  ___ No

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

Student Signature (Parent Signature if student is under 18 yrs. old)  __________________________

Date  __________________________
PART II: Clinical Assessment By Healthcare 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 and proceed to 2 or 3:
   □ 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

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: _____/_____/_____
   Location: Lt Forearm   Rt. Forearm
   M    D    Y

   Date Read: _____/_____/_____
   Result: _____ mm of induration
   M    D    Y

   Interpretation:     _____ Positive     _____ Negative

3. **Interferon Gamma Release Assay**

   Date Collected :___/___/___
   Date Resulted: ___/___/___
   Interpretation:     _____ Positive     _____ Negative

   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 and other immunosuppressed persons (including receiving equivalent of >15mg/d of prednisolone for >1 month.)
• HIV-infected persons

>10 mm is positive:
• Recent arrivals to the U.S. (<5 yrs) from high prevalence areas or who resided in one for a significant* amount of time
• Injection drug users
• Mycobacteriology laboratory personnel
• Residents, employees, or volunteers in high-risk congregate settings
• Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight

>15mm is positive
• Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

**IF A TUBERCULIN SKIN TEST (TST) IS PERFORMED AND IS POSITIVE, A QUANTIFERON GOLD TEST OR CHEST X-RAY IS REQUIRED. IF THE QUANTIFERON GOLD TEST OR CHEST X-RAY IS ALSO POSITIVE, AN ADDITIONAL TREATMENT PLAN MUST BE ATTACHED/SUBMITTED WITH THIS FORM**
CONSENT TO TREATMENT OF MINOR

To be completed by parent or legal guardian of student under the age of 18.

Student's Name: ___________________________ Date of Birth: ____________ Last 4 of SSN: ________________

Parent/Legal Guardian Name: ________________________________________________________________

I, the undersigned, parent/guardian of __________________________________________________________, a minor, do hereby state that I have legal custody of the aforesaid child who has enrolled in The University of the South. I hereby authorize the licensed healthcare professionals of the University's Wellness Center to provide medical treatment for my child, and I consent to any examination (including X-ray examination), anesthetic, blood transfusion, medication, medical or surgical treatment, and/or hospital care that is deemed advisable by, and is to be rendered under the general or special supervision of any licensed healthcare professional, whether diagnoses or treatment is rendered at the Wellness Center or at the office of any licensed healthcare provider or a hospital. I agree to assume financial responsibility for all expenses of such care.

It is understood that this authorization is given in advance of any specific diagnosis or treatment, or hospital care being required, and is given to provide specific consent to any and all such diagnoses, treatment, or hospital care that any aforementioned healthcare provider in the exercise of his/her best judgment may deem advisable.

I understand that this authorization will be in effect until my child reaches age 18.

___________________________  __________________________  __________________________
Parent/Legal Guardian Signature  Relationship to Patient  Date