



## INTRODUCTORY PAGE

**\*\*\*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 15<sup>th</sup> for fall semester (spring transfer deadline December 31<sup>st</sup>). 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](mailto:healthforms@sewanee.edu)

**CONTACT INFORMATION: (Phone):** 931-598-1270

**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.

All parents and students should review the University's website regarding Covid-19 information.

<https://new.sewanee.edu/2019-novel-coronavirus-covid-19/>

For the most up-to-date information about wellness center services, please visit our webpage at:

<https://new.sewanee.edu/campus-life/flourishing/wellness-commons/university-wellness-center/>

**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](mailto: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/](http://www.hhs.gov/ocr/privacy/)).



University Wellness Center  
604 University Ave.  
SPO 1182  
Sewanee, TN 37383

**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 MAY NOT PROVIDE COVERAGE IN THE SEWANEE AREA**

**HEALTH INSURANCE:** \_\_\_\_\_

NAME & ADDRESS OF INSURANCE COMPANY		TELEPHONE
_____ Name of Policy Holder	_____ Policy Holders DOB & SSN	_____ Employer
_____ Policy ID/Certificate Number	_____ Group Number	<input type="checkbox"/> HMO <input type="checkbox"/> 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**

	AGE	OCCUPATION	STATE OF HEALTH/CHRONIC ILLNESSES	IF DECEASED, AGE AT DEATH	CAUSE OF DEATH
PARENT/GUARDIAN					
PARENT/GUARDIAN					
SIBLINGS					

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.

<input type="checkbox"/>	Abnormal Pap Smear	<input type="checkbox"/>	Dental Appliance Use	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	Mononucleosis (Year )	<input type="checkbox"/>	Self- Injurious Behavior
<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	MRSA/Skin Infections	<input type="checkbox"/>	Sexually Transmitted Disease
<input type="checkbox"/>	Anemia/Blood Disorder	<input type="checkbox"/>	Dizziness/Fainting	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	Neck Pain/Injury	<input type="checkbox"/>	Shortness of Breath
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Drug/Alcohol	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Nervous Stomach	<input type="checkbox"/>	Shoulder Dislocation/Surgery
<input type="checkbox"/>	Asthma/Inhaler Use	<input type="checkbox"/>	Eye Injury or Disease	<input type="checkbox"/>	Irregular Menses/Cramps	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	Skin Problems/Eczema
<input type="checkbox"/>	Back Pain	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	Orthotics	<input type="checkbox"/>	Smoking/Tobacco Abuse
<input type="checkbox"/>	Bone/Joint Disorder	<input type="checkbox"/>	Gallbladder/Gallstone	<input type="checkbox"/>	Knee Problems	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Thyroid
<input type="checkbox"/>	Breast Mass	<input type="checkbox"/>	Gout	<input type="checkbox"/>	Kidney Infection/Stones	<input type="checkbox"/>	Recurrent Bronchitis	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Head Injury/Concussion	<input type="checkbox"/>	Learning Disability	<input type="checkbox"/>	Recurrent Sinusitis	<input type="checkbox"/>	Ulcer - Stomach/Duodenal
<input type="checkbox"/>	Cardiac	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	Reproductive Surgery	<input type="checkbox"/>	Urinary Tract Infections
<input type="checkbox"/>	Chemotherapy/Radiation	<input type="checkbox"/>	Heart Burn/Acid Reflux	<input type="checkbox"/>	Malaria (Year )	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Vision
<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	COVID-19 (Date )

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\*\***

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ BMI: \_\_\_\_\_ B/P: \_\_\_\_\_ PULSE: \_\_\_\_\_ TEMP: \_\_\_\_\_ RESP: \_\_\_\_\_

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

	WNL	ABN	COMMENTS
Ears, Nose, and Throat			
Head and Neck			
Cardiovascular			
Chest and Lungs			
Abdomen			
Genitalia / Hernia			(Date of last Gyn Exam-if applicable)
Orthopedic Screening			
a. Neck			
b. Spine			
c. Shoulders			
d. Arms & Hands			
e. Hips			
f. Knees			
g. Legs & Feet			

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. (Deadline for students arriving/transferring in Spring is December 31<sup>st</sup>)

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)**  
M D YR

**MMR** (measles, mumps, rubella) – two doses are required or proof of positive antibody titer.

1. Dose 1 (at age 12 mos. or later) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR

2. Dose 2 (at least 28 days after 1<sup>st</sup> dose) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR

**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 \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR

**Hepatitis B** – three doses of Hepatitis B are required or proof of positive antibody titer.

1. Dose (1) \_\_\_\_/\_\_\_\_/\_\_\_\_ (2) \_\_\_\_/\_\_\_\_/\_\_\_\_ (3) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR M D YR M D YR

**Polio** – if all dates of primary series not known, three primary series are required.

1. IPV and/or OPV (1) \_\_\_\_/\_\_\_\_/\_\_\_\_ (2) \_\_\_\_/\_\_\_\_/\_\_\_\_ (3) \_\_\_\_/\_\_\_\_/\_\_\_\_ (4) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR M D YR M D YR M D YR

**Varicella** – two doses are required or proof of positive antibody titer.

1. Varicella Immunizations: (1) \_\_\_\_/\_\_\_\_/\_\_\_\_ (2) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR M D YR

**COVID-19 Vaccine** – Johnson & Johnson / Moderna / Pfizer – (Circle One)

\*Dates of COVID-19 Vaccine are not required by the University to be compliant. Dates of vaccine are recommended only\*

Dose (1) \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose (2) \_\_\_\_/\_\_\_\_/\_\_\_\_ (Booster) \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR M D YR M D YR

**COVID-19 Disease Date (most recent):** \_\_\_\_/\_\_\_\_/\_\_\_\_  
M D YR

**Tuberculosis (TB) Screening Questionnaire (See page 7 and 8)**

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

**Recommended Immunizations**

**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) \_\_\_\_/\_\_\_\_/\_\_\_\_

**Meningococcal B (Bexsero or Trumenba) – Circle One**

1. Dose (1) \_\_\_\_/\_\_\_\_/\_\_\_\_ (2) \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of health care provider: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Tuberculosis (TB) Screening Questionnaire (See page 7 and 8)**

The Questionnaire must be completed by all students. If a student answers YES to any of the screening questions on page 7 additional testing is required and your healthcare provider must complete page 8.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of  $\geq 20$  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

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Last 4 of SSN: \_\_\_\_\_

**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: \_\_\_/\_\_\_/\_\_\_  
                  M      D      Y

Location: Lt Forearm    Rt. Forearm

Date Read: \_\_\_/\_\_\_/\_\_\_  
                  M      D      Y

Result: \_\_\_\_\_ mm of induration

Interpretation:    \_\_\_ Positive    \_\_\_ Negative

**3. Interferon Gamma Release Assay**

Date Collected : \_\_\_/\_\_\_/\_\_\_  
                          M      D      Y

Date Resulted: \_\_\_/\_\_\_/\_\_\_  
                          M      D      Y

Interpretation:    \_\_\_ Positive    \_\_\_ Negative

**\*\*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