SEWANEE
THE UNIVERSITY OF THE SOUTH

INTRODUCTORY PAGE

*****PLEASE READ THE FOLLOWING INFORMATION CAREFULLY BEFORE COMPLETING THE FORMS*****

The Health Form (pgs 2 - 5) must be completed, returned, and verified by the University Wellness Center Health Service personnel. Deadline for summer school students is May 15th. Deadline for School of Theology is July 31st. The health form must be complete or you must have a plan in place with Health Service personnel to complete your forms before the deadline.

All portions of the health form must be scanned and uploaded in PDF format via the following link:
https://universityofthesouth.sharefile.com/r-r3cc15fa39ebf478b8e807a9651739cfd

The link requires the following fields: email, first name and last name.
"Company" is not a required field and may be skipped.

Students may also fax their information to **833-642-0898**. 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): 931-598-1270
MAILING: University Wellness Center
University Health Service
SPO 1182
Sewanee, TN 37383

HEALTH FORM (Pgs 2 - 5)
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 an 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.

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. Anyone who does not have documentation of immunizations, will need to have blood titers drawn to check immunity status. If a titer is non-reactive, the patient must **repeat the appropriate immunization series** to meet University requirements.

UNIVERSITY OF THE SOUTH
University Wellness Center

Patient Name:_____ **DOB**:_____

Personal Mailing Address (NOT SOT): _____
Street Address or PO Box City State Zip

Contact Information: _____ / _____@sewanee.edu
(Cell/Home) (Email)

Insurance: __Please submit a copy of the front and back of your insurance card with this form_____

Allergies: _____

Current Medications: _____
_____

Date of your last Physical Exam: _____ **Date of your most recent lab/bloodwork**: _____

PAST MEDICAL HISTORY:
Do you have now, or have you ever had, symptoms noted below?

Yes	No		Yes	No		Yes	No	
		Frequent or Severe Headache			Dizziness/Fainting/Blackouts			Chicken Pox
		Epilepsy/Seizures			Frequent Indigestion			German Measles (Rubella)
		Head Injury			Stomach/Intestinal Trouble			Measles (Rubeola)
		Eye Trouble/Corrective Lenses			Gallbladder Trouble/Stones			Mumps
		Ear, Nose or Throat Trouble			Hepatitis			Mononucleosis
		Hearing Difficulty			Peptic Ulcer			Polio
		Thyroid Problems			Recurrent Diarrhea			Scarlet Fever
		Asthma			Recent Weight Change			Tuberculosis
		Chronic Cough			Eating Disorder			Surgery: (Appendix)
		Pneumonia			Diabetes			(Tonsils)
		Shortness of Breath			Kidney/Bladder Disease			(Hernia Repair)
		Sleep Disorder			Kidney Stones			(Other)
		Heart Trouble			Menstrual Disorder			(Other)
		High Cholesterol			Abnormal Pap			Congenital Problems
		High Blood Pressure			Hernia			Frequent Anxiety
		Chest Pain/Pressure in Chest			Sexually Transmitted Disease			Frequent Depression
		Anemia			Arthritis			Attempted Suicide
		Blood Disorder			Back Injury			Any Drug/Narcotic Habit
		Cancer			Bone/Joint Problem			Behavior Disorder

Details for any "Yes" responses: _____
_____
_____

IMMEDIATE FAMILY MEDICAL HISTORY (Parents, Sibling, Children, Grandparents): Please list any significant family history illness/disease and your relationship to that family member (i.e. cancer, high blood pressure, asthma, diabetes, thyroid disorder, sudden death, etc).

1. _____
2. _____
3. _____
4. _____

GRADUATE STUDENT IMMUNIZATION FORM

PLEASE SUBMIT IMMUNIZATIONS ON THIS FORM. All students are required to have the following immunizations prior to enrollment in classes. If you have any questions, please direct them to University Health Service: (931) 598-1270. Please fax the completed forms to 833-642-0898 or scan (pdf format) and upload via the link on Page 1. Hardcopies may be mailed to University Health Service, University Wellness Center, SPO 1182, Sewanee, TN 37383-1000

Student's Name: _____ Date of Birth: _____ Last 4 of SSN: _____

MMR (measles, mumps, rubella) – two doses of the vaccine or a positive antibody titer is required to meet the requirements.

1. Dose 1 (at age 12 mos. or later) ____/____/____ (M D YR)
2. Dose 2 (at least 28 days after 1st dose) ____/____/____ (M D YR)
3. Mumps Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)
   Rubella Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)
   Rubeolla Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

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 the vaccine or a positive antibody titer is required to meet the requirements.

1. Dose (1) ____/____/____ (M D YR) (2) ____/____/____ (M D YR) (3) ____/____/____ (M D YR)
2. Hepatitis B Surface Antibody Titer ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

Varicella – Two doses of the vaccine or a positive antibody titer is required to meet the requirements.

1. Varicella Immunizations: (1) ____/____/____ (M D YR) (2) ____/____/____ (M D YR)
2. Varicella Antibody Titer: ____/____/____ (M D YR) Result: ____ (Reactive/Immunity) ____ (Non-Reactive)

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) ____/____/____ (M D YR) Dose (2) ____/____/____ (M D YR) (Booster) _____/_____/_____ (M D YR)

COVID-19 Disease Date (most recent): _____/_____/_____ (M D YR)

STUDENTS AGE 22 AND UNDER ARE ALSO REQUIRED TO HAVE ONE MENINGOCOCCAL VACCINE AFTER AGE 16

Meningococcal (A, C, Y, W-135) – One dose required after the sixteenth birthday.

1. Menactra/Menveo ____/____/____ (M D YR) **(MUST BE AFTER AGE 16)**

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

Tuberculosis (TB) Screening Questionnaire – See page 4 and 5

Signature of Health Care Provider: _____

Phone: (_____) _____ Fax: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

Tuberculosis (TB) Screening Questionnaire

The Questionnaire must be completed by all students. If you answer YES to any of the questions on page 4, your healthcare provider will need to perform additional testing and complete page 5 of the TB Questionnaire.

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

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

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 of the Tuberculosis Screening Questionnaire. 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

   Result: _____ mm of induration

   Date Read: _____/_____/_____ (M D Y) 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****