STUDENT'S MEDICAL HISTORY FORM

Gallaudet University
Peter J. Fine Student Health Services
800 Florida Ave, NE, Washington, DC 20002-3695
(202) 651- 5090 v/tty (202) 651- 5743 fax

SHS Use Only
Reviewed by:_____________
Date: ___________________

TB assessment form is required of all students regardless of age. The tetanus/diptheria is STRONGLY RECOMMENDED. For those students attending class over the age of 26 must complete the Student Health Service form and the TB assessment form. Students attending class under the age of 26 must submit the Student Health Service form, the TB assessment form and must show proof of all of the following immunizations:

- MMR (measles, mumps, and rubella) must have two injections
- Varicella (chickenpox) – 2 doses
- Tetanus/Diphtheria – within the last 10 years
- Meningitis
- Hepatitis Series
- Polio

Name:____ Date of Birth: ______-______-______
Title First Middle Last

Place of Birth:______________________________ Sex: ❑ M ❑ F Religion: ____________________
City State/Province

Marital Status: ❑M ❑S ❑W ❑ D ❑Sep Social Security #: _________-_______-_________

Home Address: ____________________ City: ______________ State: ___________ Zip: ___________

Phone/Home: ________________ Student I.D. Number: ________________ Email: ________________
❑ Voice ❑ TTY ❑ VP

List the names, addresses, and phone numbers of two people who should be notified in case of emergency.

#1
Name: _______________ Relationship: ______________
Full Address: ________________________________
Phone Numbers: Home ( ) ______________________
❑ Voice ❑ TTY ❑ VP
Work ( ) ______________________
❑ Voice ❑ TTY ❑ VP
Email/Pager: ______________________

#2
Name: _______________ Relationship: ______________
Full Address: ________________________________
Phone Numbers: Home ( ) ______________________
❑ Voice ❑ TTY ❑ VP
Work ( ) ______________________
❑ Voice ❑ TTY ❑ VP
Email/Pager: ______________________

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

IMMUNIZATIONS	Original Series (Full Dates)	Booster (Full Dates)	Booster (Full Dates)	Booster (Full Dates)
Tetanus/Diphtheria				
Measles, Mumps, Rubella (MMR)				
Varicella (chicken pox)				
Hepatitis B (HEP-B)				
Meningitis				
Polio				
Has the patient ever received BCG?				

TUBERCULOSIS TESTING	Date	Result and Date	Date	Result and Date	Date	Result and Date
Tuberculin Mantoux (PPD 5 TU)						
Chest X-Ray (if PPD Positive)						

Signature: ____ Title: ________________________

Return this form to the Peter J. Fine Student Health Center prior to the start of your class.

TUBERCULOSIS RISK ASSESSMENT FORM

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Reviewed by:_____________
Date: ___________________

Name:____ SSN:____

The Centers for Diease Control and Prevention and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at increased risk of tuberculosis. This risk may be as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for you. IF YOU CHECK ONE OF THE BOXES IN SECTIONS 1-4, YOU ARE REQUIRED TO HAVE A TUBERCULOSIS (PPD) SKIN TEST.

Check the box at the bottom of the page if sections 1-4 do not apply to you. Sign and date the form at the bottom. If you are under 18 years of age, your parent or guardian will need to sign the form.

☐ Section 1: Check this box if you have any of the following Possible Symptoms of Tuberculosis:
- Unexplained weight loss
- Unexplained elevation of temperature for more than one week
- Unexplained night sweats
- Unexplained persistent cough for more than 30 weeks
- Unexplained cough productive of bloody sputum

☐ Section 2: Check this box if you have any of the following Risk Factors for Tuberculosis Infection:
- Close contact with a known case of active tuberculosis
- Use of illegal injected drugs
- HIV (Human Immunodeficiency Virus) Infection
- Heatlh Care Worker
- Resident or employee in a congregate living setting (nursing home, homeless shelter, correctionaly facility)

☐ Section 3: Check this box if you have any of the following Risk Factors for Tuberculosis Diease:
- diabetes mellitus
- lymphoma, leukemia or cancer of the head, neck or lung
- silicosis
- gastrectomy or rejuno-ideal by pass
- long-term immunosuppressive therapy
- greater than 10% below ideal body weight

☐ Section 4: Check this box if, in the last years, you have lived or traveled for 30 days or more to any of the following AREAS with a High Prevalence of Tuberculosis as defined by the Whole Health Organization and the state health department:
- Africa - all countries
- Asis/Southeast Asisa/Pacific Islands - all countries
- North, Central & South American - Argentina, Bahamas, Belize, Brazil, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
- Europe - Belarus, Bosnia, Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
- Middle East - Bahrain, Iran, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Turkey, Yemen

☐ No, none of the items listed in section 1 - 4 apply to me.

____ ______________________________

Student Signature (Parent Signature if student under 18 years of age Date