HEALTH SERVICES FORMS INSTRUCTIONS

Anyone living on the Brenau University campus must complete the Health Forms indicated below. These forms must be on file with Health Services prior to the first day of class or prior to living on campus. Please read the instructions, complete the forms and return them to Brenau University, Office of Admissions, 500 Washington Street SE, Gainesville, GA 30501 or via fax to 770.538.4701.

PERSONAL INFORMATION AND CONSENT FOR SERVICES

Information provided will only be used to provide you with good medical care. It is strictly for use by Health Services and will not be released without your knowledge and written consent.

PHYSICAL EXAMINATION

Must be submitted by anyone living on campus and must be completed by a Physician/Healthcare Provider, NOT a family member.

HEALTH HISTORY

Must be completed by the student.

CERTIFICATE OF IMMUNIZATION

Brenau University’s policy is to require certain immunizations for anyone living on campus. These requirements include documented proof of immunity to measles, mumps, rubella, varicella (chicken pox), tetanus, and hepatitis B. Please note that dates of immunizations are required and a Healthcare Provider must sign the immunization form. Health Services does recognize that some patients may submit an exemption for religious purposes. To obtain exempt status, students must present a notarized letter stating the exemption is for religious purposes. This letter will be included in the student health record.

TB screening is not a vaccination and is required for anyone living on campus thus it cannot be exempted.

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

Anyone living on campus must complete the form by answering all five questions and signing the form. It is also recommended that this form be resubmitted 8 weeks after returning from any travel outside of the United States.

TUBERCULOSIS (TB) RISK ASSESSMENT

If risk is identified on TB Screening Questionnaire the following steps must be taken:
1. Patient/Student must complete Section A
2. Patient/Student’s healthcare provider must complete Section B

MENINGITIS VACCINE/INFORMATION

In January 2004, Georgia law began requiring all public and private post-secondary educational facilities to give students residing in campus housing information about meningococcal disease and vaccine. Brenau University also allows non-students to reside on campus in rental housing. Since it is impossible to distinguish between the two populations, Brenau University requires anyone living on campus to complete the Meningococcal Disease/Information Form. The form must be completed stating that a person has been informed of the risks presented by Meningitis and has received the meningococcal vaccine OR declined to be vaccinated. If the person is a minor, their guardian or parent must sign the form as well.
HEALTH SERVICES PERSONAL INFORMATION & CONSENT

This information is strictly confidential and will be used by health Services Staff solely to provide you with good medical care. Information will not be released without your knowledge and written consent.

Personal Information (Please Print in Ink or Type)

Name: __________________________________________ Birthday: _______ Age: _______

Last, First Middle

Home Address: ____________________________________________ Home Phone: ___________

Street City State Zip

Email Address: __________________________________________ Cell Phone: ___________

If you are under 18 years of age, please provide your parent/guardian information:

Parent/Guardian Name: __________________________________________

Address: __________________________________________ Email Address: ___________

Last, First Middle

Street City State Zip

Telephone #: __________________________________________

Emergency Contact

Contact Name: __________________________________________ Relationship: ___________

Last, First Middle

Address: __________________________________________ Email Address: ___________

Street City State Zip

Telephone #: __________________________________________

Consent for Diagnostic and Treatment Procedures

All statements on this Health Form are true to the best of my knowledge. I authorize the healthcare providers at Brenau University to perform diagnostic and treatment procedures as may be deemed necessary.

Patient Signature: __________________________________________ Date: ___________

If patient is under the age of 18 please provide your parent/guardian signature:

Parent/Guardian Signature: __________________________________________ Date: ___________

Family Educational Rights and Privacy Act of 1974 (FERPA), published by the Department of Health, Education and Welfare requires the patients written approval before parents, guardians, or spouse may be given medical information.
HEALTH SERVICES PERSONAL INFORMATION & CONSENT

This information is strictly confidential and will be used by health Services Staff solely to provide you with good medical care. Information will not be released without your knowledge and written consent.

Personal Information (Please Print in Ink or Type)

Name: ___________________________________________ Birthday: _______ Age: ______

   Last,    First     Middle     Month/Day/Year

Home Address: ___________________________________________ Home Phone: __________________

   Street   City     State     Zip

Email Address: ___________________________________________ Cell Phone: __________________

   __________________

If you are under 18 years of age, please provide your parent/guardian information:

Parent/Guardian Name: ___________________________________________

   Last,    First     Middle

Address: ___________________________________________ Email Address: __________________

   Street   City     State     Zip

Telephone #: ___________________________________________ Home     Cell     Business

Emergency Contact

Contact Name: ___________________________________________ Relationship: _______________

   Last,    First     Middle

Address: ___________________________________________ Email Address: __________________

   Street   City     State     Zip

Telephone #: ___________________________________________ Home     Cell     Business

Consent for Diagnostic and Treatment Procedures

All statements on this Health Form are true to the best of my knowledge. I authorize the healthcare providers at Brenau University to perform diagnostic and treatment procedures as may be deemed necessary.

Patient Signature: ___________________________________________ Date: _______________

If patient is under the age of 18 please provide your parent/guardian signature:

Parent/Guardian Signature: ___________________________________________ Date: _______________

Family Educational Rights and Privacy Act of 1974 (FERPA), published by the Department of Health, Education and Welfare requires the patients written approval before parents, guardians, or spouse may be given medical information.
HEALTH SERVICES PHYSICAL EXAMINATION

This form must be completed by your Physician/Healthcare provider.

PATIENT INFORMATION (please print in ink or type)

Name: ____________________________ Birthday: ____________________________

Last, First Middle Month/Day/Year

PHYSICIAN/PROVIDER SUMMARY

HT _______ WT _______ BP _______

<table>
<thead>
<tr>
<th>Normal/Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEENT</td>
<td>□ / □</td>
</tr>
<tr>
<td>SKIN</td>
<td>□ / □</td>
</tr>
<tr>
<td>HEART</td>
<td>□ / □</td>
</tr>
<tr>
<td>LUNGS</td>
<td>□ / □</td>
</tr>
<tr>
<td>ABDOMEN</td>
<td>□ / □</td>
</tr>
<tr>
<td>MUSCULOSKELETAL</td>
<td>□ / □</td>
</tr>
<tr>
<td>NEUROLOGICAL</td>
<td>□ / □</td>
</tr>
</tbody>
</table>

List ALL past or present medical conditions that we need to be aware of:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Are there any conditions (i.e., recent surgery or illness, chronic health problems) that would limit the patient from participating in physical activities? Circle one: YES NO

If you answered YES, please explain:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Does the patient take any medication? If so, please list:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

If the patient is under a current treatment program that you would like to continue, please enclose/attach pertinent medical history and recommendations.

Signature of Healthcare Provider: ____________________________ Date: __________

Please Print: (or use office stamp)

Healthcare Provider Name or Office ____________________________

Address: _______________________________________________________

Phone: ____________________________ Fax: ____________________________
HEALTH SERVICES HEALTH HISTORY

This form is to be completed by the patient.

PERSONAL INFORMATION (please print in ink or type)

Name: ____________________________ Birthday: _______________ Last, First Middle Month/Day/Year

HEALTH HISTORY

Do you have or have you had any of the following? If yes, please explain.

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acid Reflux</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anemia/Blood Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appetite Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronchitis/Chronic Cough</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Ear Infections</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colitis, Ulcerative/Spastic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness/Fainting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy/Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Murmur</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV Positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoglycemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insomnia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Injury</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Limitations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psoriasis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seasonal Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shortness of Breath</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinusitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal Disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STDs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strep Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Concerns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ulcers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unconsciousness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you answered yes to any of the previous conditions, please explain:___________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________

Allergies (list ALL medications, food, pollen, environmental, or insect/animal allergies):__________________________
____________________________________________________________________________________________________________
Are there any other medical conditions or concerns that we need to be aware of? If so please list below or add additional documentation:____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
____________________________________________________________________________________________________________
HEALTH SERVICES IMMUNIZATION RECORD

Please complete this form in its entirety or you may send a state certified copy of your immunization record. This form must be submitted by all persons living on campus.

PERSONAL INFORMATION (please print in ink or type)

Name:_________________________________________________________ Birthday:________________________

Last, First Middle Month/Day/Year

REQUIRED IMMUNIZATIONS (to be completed by Healthcare Provider)

All information must be in English.

________________________________

MMR (Measles, Mumps, Rubella): Two doses are required for persons born after January 1, 1957
Dose 1 given at age 12 months or later
Dose 2 given at least 28 days after first dose

# 1 dose date: __/___/____
# 2 dose date: __/___/____

__________________________________________________________

TETANUS-DIPHTHERIA (Tdap booster recommended for ages 11-64 unless contraindicated):
Date of most recent booster dose: __/___/____
Type of most recent booster: Td _____ Tdap _____

__________________________________________________________

VARICELLA (chicken pox): Two doses of vaccine or history of disease
Date of 1st dose: __/___/____
Date of 2nd dose: __/___/____
or history of disease - Year: __________

__________________________________________________________

HEPATITIS B: Three doses of vaccine for All PERSONS living on campus
#1 dose date: __/___/____
#2 dose date: __/___/____
#3 dose date: __/___/____

Signature of Healthcare Provider: ____________________________________________ Date:__________

Please Print: (or use office stamp)
Healthcare Provider Name or Office__________________________________________________________

Address:_______________________________________________________________________________

Phone:________________________________________ Fax:____________________________________
Health Services
Tuberculosis (TB) Screening Questionnaire

Please complete this form in its entirety. This form must be submitted by all persons living on campus.

Personal Information (please print in ink or type)

Name: ___________________________ Last, First Middle ___________________________ Birthday: _____________ Month/Day/Year

Please Answer the Following Questions (circle YES or NO)

1. Have you ever had a positive TB skin test? YES NO
2. Have you ever had close contact with anyone who was sick with TB? YES NO
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * YES NO
4. Have you ever traveled to/in one or more of the countries listed below? * YES NO
5. Have you ever been vaccinated BCG? YES NO

*If YES is answered for question #3 and/or #4 please CIRCLE the country from the list provided below.

<table>
<thead>
<tr>
<th>Country</th>
<th>Country</th>
<th>Country</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>Congo</td>
<td>Japan</td>
<td>Nicaragua</td>
</tr>
<tr>
<td>Albania</td>
<td>Côte d’Ivoire</td>
<td>Kazakhstan</td>
<td>Niger</td>
</tr>
<tr>
<td>Angola</td>
<td>Croatia</td>
<td>Kenya</td>
<td>Nigeria</td>
</tr>
<tr>
<td>Argentina</td>
<td>DPR-Korea</td>
<td>Kiribati</td>
<td>Pakistan</td>
</tr>
<tr>
<td>Armenia</td>
<td>DR-Congo</td>
<td>Kuwait</td>
<td>Palau</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Djibouti</td>
<td>Kyrgyzstan</td>
<td>Panama</td>
</tr>
<tr>
<td>Bahrain</td>
<td>Dominican Republic</td>
<td>Lao People’s - DR</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Ecuador</td>
<td>Latvia</td>
<td>Paraguay</td>
</tr>
<tr>
<td>Belarus</td>
<td>El Salvador</td>
<td>Lesotho</td>
<td>Peru</td>
</tr>
<tr>
<td>Belize</td>
<td>Equatorial Guinea</td>
<td>Liberia</td>
<td>Philippines</td>
</tr>
<tr>
<td>Benin</td>
<td>Eritrea</td>
<td>Libyan Arab Jamahiriya</td>
<td>Poland</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Estonia</td>
<td>Lithuania</td>
<td>Portugal</td>
</tr>
<tr>
<td>Bolivia</td>
<td>Ethiopia</td>
<td>Madagascar</td>
<td>Qatar</td>
</tr>
<tr>
<td>Bosnia and Herzegovina</td>
<td>Fiji</td>
<td>Malawi</td>
<td>Republic of Korea</td>
</tr>
<tr>
<td>Botswana</td>
<td>Gabon</td>
<td>Malaysia</td>
<td>Republic of Moldova</td>
</tr>
<tr>
<td>Brazil</td>
<td>Gambia</td>
<td>Maldives</td>
<td>Romania</td>
</tr>
<tr>
<td>Brunei Darussalam</td>
<td>Georgia</td>
<td>Mali</td>
<td>Russian Federation</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Ghana</td>
<td>Marshall Islands</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Guam</td>
<td>Mauritania</td>
<td>Saint Vincent and the</td>
</tr>
<tr>
<td>Burundi</td>
<td>Guatemala</td>
<td>Mauritius</td>
<td>Grenadines</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Guinea</td>
<td>Micronesia</td>
<td>Sao Tome and Principe</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Guinea-Bissau</td>
<td>(Federated States of)</td>
<td>Senegal</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Guyana</td>
<td>Mongolia</td>
<td>Seychelles</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Haiti</td>
<td>Morocco</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>Chad</td>
<td>Honduras</td>
<td>Mozambique</td>
<td>Singapore</td>
</tr>
<tr>
<td>China</td>
<td>India</td>
<td>Myanmar</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>Colombia</td>
<td>Indonesia</td>
<td>Namibia</td>
<td>Somalia</td>
</tr>
<tr>
<td>Comoros</td>
<td>Iraq</td>
<td>Nepal</td>
<td>South Africa</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Sudan</td>
<td>Suriname</td>
<td>Swaziland</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>Congo</td>
<td>Japan</td>
<td>Nicaragua</td>
</tr>
</tbody>
</table>

Source: World Health Organization, Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

If the answer is NO to all of the above questions, no further action is required.

Patient Signature: ___________________________ Date: _____________

Brenau University requires that a healthcare provider complete a tuberculosis risk assessment prior to the first day of classes.
# Health Services
## Tuberculosis (TB) Risk Assessment

Both Sections A & B are required and must be completed in their entirety if TB Screening Questionnaire indicates risk.

### Patient Information (please print in ink or type)

Name: ___________________________  
Last, First, Middle  
Birthday: ________________________

### To Be Completed by Person Living On Campus

1. Recent close contact with someone with infectious TB disease  
   YES _____  NO _____
2. Born or travel in high prevalence area (Africa, Asia, Eastern Europe, Central or South America)  
   YES _____  NO _____
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease  
   YES _____  NO _____
4. Have HIV/AIDS  
   YES _____  NO _____
5. Have received an organ transplant  
   YES _____  NO _____
6. Immunosuppressed (equivalent of >15mg/day of prednisone for >1 month of TNF-a antagonist)  
   YES _____  NO _____
7. History of illegal drug use  
   YES _____  NO _____
8. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals and other health care facilities)  
   YES _____  NO _____
9. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, Hodgkin’s disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]  
   YES _____  NO _____

### To Be Completed by Healthcare Provider

1. Does the patient have signs or symptoms of active tuberculosis disease?  
   YES _____  NO _____

   If YES, proceed with additional evaluation to exclude active tuberculosis disease including Tuberculin skin testing, chest x-ray, and sputum evaluation as indicated. If NO proceed to #2 or #3.

2. Tuberculin Skin Test (TST):  
   (TST result should be recorded as actual millimeters (mm) or induration, transverse diameter; if no induration, writes “0”)

   **Interpretation Guidelines for Healthcare Provider:**

   **Interpretation:**
   - Normal
   - Abnormal

   **Interpretation:** POSITIVE _____  NEGATIVE _____

   (based on mm of induration as well as risk factors)

3. Interferon Gamma Release Assay (IGRA)  
   Date given __/__/____ ( specify method by circling one)  

4. Chest x-ray:  
   (Required if TST or IGRA is positive)  
   Date of chest x-ray: __/__/____  
   Result: Normal _____  Abnormal _____

**Signature of Healthcare Provider:** ___________________________  
Date: _______________________

Please Print:  
(or use office stamp)

**Healthcare Provider Name or Office**

**Address:** ____________________________________________

**Phone:** ___________________________  
Fax: ___________________________
HEALTH SERVICES
MENINGOCOCCAL DISEASE/VACCINE INFORMATION

Georgia law requires ALL persons living on campus to document they have been vaccinated against meningococcal disease OR have reviewed information about the disease and elected not to be immunized.

MENINGOCOCCAL DISEASE INFORMATION

Menincococcal disease is a serious disease that can lead to death within hours of onset. In non-fatal cases, those affected experience long-term disabilities, such as brain damage, loss of limb, or deafness. The disease is a highly contagious but largely preventable infection of the fluid surrounding the spinal cord and brain. Evidence suggests that persons living in campus housing are at a moderately increased risk of contracting the disease. The meningococcal vaccine will decrease the risk of the disease. The Advisory Committee on Immunization Practices (ACIP) suggests the vaccine be administered less than 5 years before beginning school. There are currently 2 kinds of meningitis vaccine available for those who wish to pay for it, usually through your County Health Department.

PLEASE COMPLETE THE FOLLOWING

If you have had the Meningococal Vaccine, your healthcare provider must complete the following information.

Patient Name: ___________________________________________ has received the vaccine against Meningococcal Disease.
Date of Vaccine: ___/___/___

Signature of Healthcare Provider: ___________________________________________ Date: ___________
Please Print: (or use office stamp)
Healthcare Provider Name or Office ___________________________________________
Address: ________________________________________________________________
Phone:________________________________________________ Fax:________________________________

If you have NOT had the Meningococal Vaccine, please complete the following information.

I have read the above information concerning the effects of Meningococcal Disease and the recommendations for vaccination. My signature below meets Georgia Law requirement of a signed statement from persons who choose NOT to receive the vaccine.

Patient Signature: ___________________________________________ Date: ___________

If patient is under the age of 18 please provide your parent/guardian signature:

Parent/Guardian Signature: ______________________________________ Date: ___________