Franciscan University of Steubenville
Confidential Health Record Form
Student Health Services

OFFICE USE ONLY

Deposit: ____________________

Fall 20____: ________________

Spring 20____: ______________

Student ID: _________________

University Wellness Center
Franciscan University of Steubenville
1235 University Blvd. • Steubenville, OH 43952-1763
740-284-7223 • Fax: 740-422-0925

Student Health Record

This is a confidential communication between the student and Franciscan University Wellness Center. Information herein will not be transmitted to anyone without the written consent of the student.

This form must be completed in full and returned to the University Wellness Center in the enclosed envelope.

Part 1: Please answer all questions. Consult your physician or parents if necessary.

1. Student Information *Please Print*

Name: ____ Male ❑ Female ❑ Birth Date: ________ / ________ / ________
Last First Middle

Home Address: ________________________________ Social Security #: ________________________

City: ________________________________ State: __________ ZIP: ______________

Contact Information: Home Phone: ______________________ Mobile phone: ______________________

Preferred email: ______________________

2. Person to Notify in Case of Emergency

Name: ______________________________ Relationship to student: ______________________

Telephone Numbers: Home: ________________ Mobile: ________________ Work: ________________

3. Allergies

Allergies to medications: ____

Food Allergies/Other Allergies: ____

4. List any prescribed medications and regularly used over-the-counter preparations: ______________________

____

Part 2: Personal Health History

All health information is confidential and kept separate from your academic records as required by law.

If you have ever had any of the following, comment below or explain on a separate sheet.

Alcohol/drug abuse	❑ Y ❑ N	Diabetes	❑ Y ❑ N	High blood pressure	❑ Y ❑ N	Tobacco use	❑ Y ❑ N
Anxiety/panic attacks	❑ Y ❑ N	Dental issues	❑ Y ❑ N	Headaches	❑ Y ❑ N	Tuberculosis	❑ Y ❑ N
Anemia	❑ Y ❑ N	Eating disorder	❑ Y ❑ N	Recurrent ear infections	❑ Y ❑ N	Vision concerns	❑ Y ❑ N
Asthma	❑ Y ❑ N	Head injury/concussions	❑ Y ❑ N	Recurrent sinusitis	❑ Y ❑ N	Urinary Tract infections	❑ Y ❑ N
Bleeding disorders	❑ Y ❑ N	Heart problems	❑ Y ❑ N	Seizures	❑ Y ❑ N		
Bowel concerns	❑ Y ❑ N	Hepatitis	❑ Y ❑ N	STD's	❑ Y ❑ N		
Depression	❑ Y ❑ N	Hearing concerns	❑ Y ❑ N	Thyroid concerns	❑ Y ❑ N		

List any disease, illness, injury, past surgeries (including transplants), permanent disabilities, or marked health concerns that Wellness Center staff should be aware of:

____

____

OVER

Part 3: Immunizations

Complete the line items below with the Month/Day/Year of EACH immunization.

Submit an official immunization record with this form. Please attach.

Tetanus/Diphtheria Booster ______ /______ /______ , ______ /______ /______ , ______ /______ /______ , ______ /______ /______
M D YR, M D YR, M D YR, M D YR

Haemophilus Influenzae B ______ /______ /______ , ______ /______ /______ , ______ /______ /______ , ______ /______ /______
M D YR, M D YR, M D YR, M D YR

Polio ______ /______ /______ , ______ /______ /______ , ______ /______ /______
M D YR, M D YR, M D YR

Hepatitis A ______ /______ /______ , ______ /______ /______
M D YR, M D YR

Measles/Mumps/Rubella ______ /______ /______ , ______ /______ /______
M D YR, M D YR

Tetanus/Diphtheria Booster ______ /______ /______
M D YR

(Recommended within 10 years of enrollment)

Varicella ______ /______ /______ , ______ /______ /______
M D YR, M D YR

Varicella *(Chicken pox)* Date of Disease ______ /______ /______
M D YR

Please Note: In order to live in one of our residence halls, you must complete the vaccination information below. This is mandated by Ohio Law ORC 3701.

Meningococcal & Hepatitis B Vaccine Status (required by ORC 3701). Must be completed to live in any residence hall.

I have read and understand the information provided about these vaccines. I understand the risks/benefits of being vaccinated against these diseases. The information given below is accurate.

Meningococcal vaccine received ❑ Yes ❑ No

Hepatitis B vaccine received ❑ Yes ❑ No

If No, MUST complete a waiver, available at franciscan.edu/health-services.

______ /______ /______ , ______ /______ /______

______ /______ /______ , ______ /______ /______ , ______ /______ /______

Tuberculosis Risk Assessment: A screening must be performed by a licensed medical doctor if you answer YES to items 1-3 below. If deemed necessary by the physician, a TB test may be given and documented with date given, date read, and result, and preferably the name of the person who read the result. If that TB test is positive, a chest X-ray will be required to determine the status of the illness.

1. Do you have unexplained fever for more than one week, unexplained weight loss, night sweats, persistent cough for more than three weeks, or a cough productive of bloody sputum? .... ❑ Y ❑ N
2. Do you have any of the following risk factors: contact with anyone with active tuberculosis, injected illegal drugs, have HIV infection, are a past or present health care worker, have cancer, diabetes, kidney disease, or chronic steroid use, been a resident, volunteer, or employee in a jail, prison, homeless shelter, nursing home, or hospital? .... ❑ Y ❑ N
3. Were you born, have lived, or recently traveled (more than 1 month) outside of the United States? .... ❑ Y ❑ N

If you answered YES to any of the above questions, you are REQUIRED to have PPD/Tuberculin Skin Testing within one year.

Date Placed: ____________ Date Read: ____________ Results: ____________

***If positive results, attach copy of chest X-ray. INH completed? ❑ Y ❑ N Dates: ____________**

I certify that the information contained herein is complete and accurate to the best of my knowledge.

______________________________ ____________

Student Signature Date

Parent/Guardian Consent for Treatment of Student Under 18 Years Old:

I, ______________________________ , parent/guardian of ______________________________ hereby give permission for such diagnostic, therapeutic, and operative procedures deemed necessary for my child.

______________________________ ____________

Signature of Parent/Guardian Date

Complete both sides.