STUDENT ID NUMBER _____ **NAME** _____
(Please print) First Middle Last

Capital University

Health Information and Immunization Form

Please Return Form by June 1 to:

Center for Health and Wellness
Capital University
1 College and Main
Columbus, OH 43209-2394
Phone: 614-236-6114 Fax: 614-236-6980

Year Entering Capital _____

Address _____
Street City State ZIP

Date of Birth _____
Month Day Year

Telephone Number (Home) _____ (Cell) _____

Emergency Contact Name _____ Relationship _____

Telephone Number _____

Emergency Contact Name _____ Relationship _____

Telephone Number _____

Chronic Medical Conditions (Please List) _____

_____

_____

Allergies _____

Primary Care Physician Name _____

Address _____
Street City State ZIP

Phone _____

STUDENT ID NUMBER _____ **NAME** _____
(Please print) First Middle Last

Mental Health Care (Psychiatric or Psychological)

Please check all that apply

Eating Disorder (anorexia, bulimia) _____

Depression/Anxiety/BiPolar Disorder, etc. _____

Suicide Attempts _____

Alcohol/Drug Treatment: Dates of Treatment _____

Outpatient Care: Diagnosis, Dates of Treatment, Medications _____

_____

Inpatient Care: Diagnosis, Dates of Treatment, Medications _____

_____

Other Medical Information

Please note any other pertinent information that you feel would be essential to the Center for Health and Wellness to ensure that you receive complete care while at Capital.

_____

_____

_____

_____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

_____

Student Signature Date

Health Insurance Information

Insurance Information _____
Company's Name Insurer's Name Company's Phone Number

Address _____
Street City State ZIP

Policy Number _____ Member/Subscriber ID _____

Group Number _____

Issue Date _____ Expires _____

STUDENT ID NUMBER _____ **NAME** _____
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Meningoccocal and Hepatitis B Status Form

Required State of Ohio Form for all Capital University Students

It is required by the State of Ohio Revised Code Section 3701.133, (B), that you **complete this form** for our files. You are not required to have these immunizations to enter the university but you must list whether you've had them or not. The Center for Health and Wellness strongly recommends that college students receive these immunizations.

Date of Birth _____

Meningoccocal Vaccine received: Yes ☐ No ☐

If yes, please give date: _____

Hepatitis B vaccine received: Yes ☐ No ☐

If yes, please give dates:

1st Dose _____

2nd Dose _____

3rd Dose _____

Health Care Provider (M.D., D.O., N.P.)

Provider's Signature _____ Date _____

Provider's Name _____
(Please print)

HEALTH CARE PROVIDER STAMP

STUDENT ID NUMBER _____ **NAME** _____
(Please print) First Middle Last

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Tuberculosis Screening Questionnaire

All Capital University students are required to provide information about overseas travel and possible exposure to tuberculosis (TB) prior to the start of classes. If you have been overseas, you should be tested for TB within 8-10 weeks after returning to the United States.

If you answer YES to any of the questions below, Capital University requires that you receive a TB skin test prior to starting school. If you are an international student, please make an appointment with the Center for Health and Wellness to discuss further testing as soon as possible. If the answer to all of the questions below is NO, no further testing or further action is required. Previous BCG vaccination does not exempt you from TB testing.

Have you ever had a **positive** TB test? _____ Yes ☐ No ☐
Date test completed

Were you born in or have you lived in or traveled to a country **OTHER** than those listed below? Yes ☐ No ☐

If so, give name of country _____ Dates of travel _____

American Regions Canada Jamaica St. Kitts & Nevis US Virgin Islands St. Lucia

European Regions Belgium Denmark Finland Germany Greece Iceland Ireland Italy Liechtenstein Malta UK Monaco Norway Netherlands San Marino Switzerland

Western Pacific Regions American Samoa Australia New Zealand

Have you ever been vaccinated with BCG? Yes ☐ No ☐

Have you had any of the following symptoms?
- 3 weeks of unexplained cough or bloody sputum? Yes ☐ No ☐
- Unexplained night sweats, weight loss or fever? Yes ☐ No ☐

Do you have any of the following risk factors to TB infection:
- Cancer or long-term immunosuppressive therapy or steroids? Yes ☐ No ☐
- Use of illegal drugs? Yes ☐ No ☐
- Close contact with an active TB patient? Yes ☐ No ☐
- HIV infection or AIDS? Yes ☐ No ☐
- Recent resident or employee of correctional facility, nursing home, homeless shelter or health care setting? Yes ☐ No ☐

** Detailed information about screening and treatment for TB can be found at the following websites:* **www.cdc.gov/TB** and **www.acha.org/topics/tb.cfm.**

HEALTH CARE PROVIDER STAMP

Provider's Name _____
(Please print)

Provider's Phone _____

STUDENT ID NUMBER _____ **NAME** _____
(Please print) First Middle Last

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Required Immunizations:

Tetanus, Diptheria, Pertussis: within the last 10 years _____ (mm) (dd) (yy)

Measles, Mumps, and Rubella: two immunizations
1. _____ (mm) (dd) (yy)
2. _____ (mm) (dd) (yy)

Polio: Completed primary series of polio immunizations Yes ☐ No ☐

Last Booster (if applicable) _____ (mm) (dd) (yy)

Meningoccocal and Hep. B Status Form Completed (page 3) Yes ☐ No ☐

Tuberculosis Questionnaire Completed (page 4) Yes ☐ No ☐

Health Care Provider (M.D., D.O., N.P.)

Provider's Signature _____ Date _____

Provider's Name _____
(Please print)

HEALTH CARE PROVIDER STAMP