



HEALTH SERVICE CENTER

316 Boulevard • Anderson, SC 29621

Welcome to Anderson University! We look forward to serving your health care needs through services offered at the Health Center and Health Education through programming while you are a student at AU.

Please mail completed form to:
ANDERSON UNIVERSITY HEALTH SERVICES
326 BOULEVARD, BOX 984
ANDERSON, SC 29621

HEALTH FORM

The primary purpose of the health form is to make available necessary health care information while you are a student at Anderson University. This information is confidential and will not be released without your consent.

- All full-time, traditional students [17-23] are required to complete a health form. The form is available on the AU web site. Go to andersonuniversity.edu; Click on Student Life; in the left column click on Health Services Form. You may also pick one up at the Health Center on campus.
- Complete **ALL** pages of the Health Form.
- Athletes this form is **REQUIRED IN ADDITION** to the forms required by the Athletic Department.
- Immunizations: Pages 3 and 4

REQUIRED:

- MMR (Measles, mumps, rubella) two doses required.
- TB screening
- Tetanus booster within the past 10 years.
- Meningitis waiver or date of immunization.

RECOMMENDED:

- Hepatitis B Vaccine: Highly recommended. A series of 3 injections.
- Varivax (varicella vaccine): Recommended if you have not had chickenpox.
- Gardasil HPV Vaccine: Series of 3 injections.

Before you mail your Health Form, please make a copy of ALL pages of the Health Form to keep for your records.

Be sure to complete the following:

PAGE NO.	FREQUENTLY MISSED ITEMS
Pages 1 and 2	COMPLETED BY STUDENT <ul style="list-style-type: none">• 3 signatures required on these pages• SS # of insurance carrier
Page 3	IMMUNIZATION DATES <ul style="list-style-type: none">• MMR x 2• Tetanus within 10 years• Meningitis waiver signed or date of immunization.• Signed by physician or submit copy of original record.
Page 4	TB Screening Questionnaire
Additional	Copy of the front and back of health insurance card

If you have any questions, please call or email.

Thank you,

Deb Taylor RN, CWE
Director, Health Services
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MEDICAL HISTORY FORM

(PLEASE PRINT OR TYPE)

Last name	First name	Middle name	Social Security #	Student ID#
Date of Birth	Male/Female	Country of Birth		
Permanent Address	City	State	Zip Code	Telephone
Local Address (Commuter)	City	State	Zip Code	Telephone
Student Cell Phone				

ATHLETE: Yes ___ No ___ Sport _____

***IF YOU ARE AN ATHLETE YOU ARE REQUIRED TO FILL OUT THIS FORM
IN ADDITION TO THE FORMS REQUIRED BY THE ATHLETIC DEPARTMENT.**

SEMESTER YOU PLAN TO ENTER: Fall Spring Year _____**CLASS:** Freshman Sophomore Junior Senior**IN CASE OF EMERGENCY, NOTIFY**

Last name	Relationship		
Work Phone	Cell Phone	Home Phone	
Address	City	State	Zip Code

PERMISSION FOR DIAGNOSTIC AND TREATMENT PROCEDURES

I hereby authorize Anderson University Health Services Center, their agents or consultants, to perform diagnostic and treatment procedures, which in their judgment become necessary while I am a student at Anderson University. I understand I am responsible for charges incurred.

Signature of Student (18 or older) _____ Date _____

PARENTS OF STUDENTS UNDER AGE 18: I hereby authorize medical treatment for my student, which may be advised or recommended by the medical staff of Anderson University health Service Center.

Signature of Parent (if student under 18) _____

THIS FORM WILL BE DESTROYED 5 YEARS AFTER STUDENT LEAVES ANDERSON UNIVERSITY

MEDICAL HISTORY FORM

PERSONAL HISTORY

ALLERGIES

YES NO

CHRONIC MEDICAL CONDITIONS: Yes No

(INCLUDING DEPRESSION, ANXIETY AND OTHER PSYCHIATRIC HISTORY)

IF YES, LIST BELOW:

Medication:		
Peanuts		
Bees-Wasps		
Other:		
Explain reaction:		

CURRENT MEDICATIONS (LIST PRESCRIPTIONS, NON-PRESCRIPTION, VITAMINS, HERBAL SUPPLEMENTS, ETC.)

 Prescription Meds: Yes No

 Over the counter Meds: Yes No

IF YES, LIST NAME & DOSAGE

IF YES, LIST NAME & DOSAGE

MEDICAL INSURANCE INFORMATION

 Do you have **HEALTH INSURANCE?** Yes No If **YES**, please complete the following.

 If you have medical insurance coverage **UNDER YOUR PARENTS**, please complete the following.

1. INFORMATION FOR PERSON WHO CARRIES THE INSURANCE

NAME _____

 SS NUMBER _____ - _____ - _____
 (REQUIRED TO FILE INSURANCE)

DATE OF BIRTH ____ / ____ / ____

2. ATTACH A COPY OF THE FRONT AND BACK OF THE INSURANCE CARD.
3. CHECK WITH YOUR INSURANCE COMPANY TO BE CERTAIN YOUR STUDENT HAS COVERAGE WHILE RESIDING AT ANDERSON UNIVERSITY.
4. STUDENT SHOULD KEEP A COPY OF THE CARD WHILE AT ANDERSON UNIVERSITY.

CONSENT FOR EMERGENCY NOTIFICATION [Read, sign and date]

I consent to Anderson University's disclosure to my parents or guardian the fact that I have been transported to an emergency room, hospitalized or deemed by the University Health Center nurses to have a serious physical or mental illness.

This consent to provide this information shall remain in full force during my enrollment at the University unless I revoke it in writing and deliver to the University's Health Center.

Consent GIVEN: SIGNATURE OF STUDENT _____ DATE _____

Consent DENIED: SIGNATURE OF STUDENT _____ DATE _____

I give the nurses in Anderson University Health Center permission to email me or leave a message on my cell or room phone.

SIGNATURE OF STUDENT _____ DATE _____



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IMMUNIZATION RECORD

MUST BE COMPLETED BY A MEDICAL PROFESSIONAL, OR ATTACH A COPY OF AN OFFICIAL IMMUNIZATION RECORD.

You may obtain your immunizations from any of the following:

- High School records
- Personal shot records
- Local Health Department
- Military records
- Previous College or University

SECTION A- REQUIRED IMMUNIZATIONS

Anderson University **REQUIRES** the following immunizations upon the recommendation of the American College Health Association, South Carolina Department of Health and US Centers for Disease Control:

1. **MMR (Measles, Mumps, Rubella):** Proof of **TWO DOSES**, unless you were born before 1957.

Dose 1 - given at age 12 months of age or later, and..... #1 ____ / ____ / ____

Dose 2 - given at age 4-6 years or later, and at least one month after the first dose..... #2 ____ / ____ / ____

OR

Laboratory/serologic evidence of immunity (attach copy of titer and date)

2. **Tetanus-Diphtheria:** Booster with Td or Tdap in the last 10 years..... ____ / ____ / ____

3. **Meningitis Vaccine - Highly RECOMMENDED for all students; however ALL STUDENTS MUST READ INFORMATION BELOW, CHECK ONE OF THE FOUR BOXES, THEN SIGN AND DATE!**

Meningococcal meningitis is an infection of the brain and its covering layers. It may cause death or permanent disability. College freshmen, especially those who live in residence halls, are at moderately increased risk for this infection. This form of meningitis is passed from person to person by close contact. There is an immunization available that affords substantial protection against this disease. The vaccines available protect for a minimum of 3-5 years. Additional information is available at <http://www.cdc.gov>

Menactra Date of administration ____ / ____ / ____ **OR**

Menomune Date of administration ____ / ____ / ____ **OR**

I would like to receive the vaccine at Anderson University.

I decline receipt of the vaccine for meningococcal meningitis.

Student Signature Required _____ **Date** ____ / ____ / ____

SECTION B- RECOMMENDED IMMUNIZATIONS

1. **Hepatitis B** If you have had this series, please fill in dates:

#1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____

2. **Varivax (varicella vaccine)**

Had disease **OR** vaccine #1 ____ / ____ / ____ #2 ____ / ____ / ____

3. **Gardasil HPV vaccine (Human Papillomavirus)** Three (3) doses of vaccine for females 11-26 years of age.

#1 ____ / ____ / ____ #2 ____ / ____ / ____ #3 ____ / ____ / ____

HEALTH CARE PROVIDER SIGNATURE or copies of official immunization records. Verification of immunization dates.

PRINT NAME _____ SIGNATURE _____

DATE ____ / ____ / ____



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Tuberculosis (TB) Screening Questionnaire

PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Have you ever had a positive TB skin test? Yes No
- Have you ever had close contact with anyone who was sick with TB? Yes No
- Were you born in one of the countries* listed below and arrived in the US within the past 5 years?
(If yes, CIRCLE the country) Yes No
- Have you ever traveled* to/in one or more of the countries listed below?
(If yes, CHECK the country/ies) Yes No
- Have you ever been vaccinated with BCG? Yes No

HIGH RISK COUNTRIES*				
Afghanistan	Congo DR	Kenya	New Caledonia	Sudan
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Suriname
Angola	Croatia	Korea-DPR	Niger	Syrian Arab Republic
Anguilla	Djibouti	Korea-Republic	Nigeria	Swaziland
Argentina	Dominican Republic	Kuwait	Niue	Tajikistan
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tanzania - UR
Azerbaijan	Egypt	Lao PDR	Pakistan	Thailand
Bahamas	El Salvador	Latvia	Palau	Timor-Leste
Bahrain	Equatorial Guinea	Lesotho	Panama	Togo
Bangladesh	Eritrea	Liberia	Papua New Guinea	Tokelau
Belarus	Estonia	Lithuania	Paraguay	Tonga
Belize	Ethiopia	Macedonia-TFYR	Peru	Tunisia
Benin	Fiji	Madagascar	Philippines	Turkey
Bhutan	French Polynesia	Malawi	Poland	Turkmenistan
Bolivia	Gabon	Malaysia	Portugal	Tuvalu
Bosnia and Herzegovina	Gambia	Maldives	Qatar	Uganda
Botswana	Georgia	Mali	Romania	Ukraine
Brazil	Ghana	Marshall Islands	Russian Federation	Uruguay
Brunei Daryssakan	Guam	Mauritania	Rwanda	Uzbekistan
Bulgaria	Guatemala	Mauritius	St. Vincent and The Grenadines	Vanuatu
Brukina Faso	Guinea	Mexico	Sao Tome and Principe	Venezuela
Barundi	Guinea-Bissau	Micronesia	Saudi Arabia	Viet Nam
Cambodia	Guyana	Moldova-Rep.	Senegal	Wallis and Futuna Islands
Cameroon	Haiti	Mongolia	Seychelles	W. Bank and Gaza Strip
Cape Verde	Honduras	Montenegro	Sierra Leone	Yemen
Central African Rep.	India	Morocco	Singapore	Zambia
Chad	Indonesia	Mozambique	Solomon Islands	Zimbabwe
China	Iran	Myanmar	Somalia	
Colombia	Iraq	Namibia	South Africa	
Comoros	Japan	Nauru	Spain	
Congo	Kazakhstan	Nepal	Sri Lanka	

If the answer is YES to any of the above questions, Anderson University requires that a health care provider complete a tuberculosis risk assessment. If the answer to all of the above questions is NO, no further testing or further action is required.

Tuberculin skin test given: ____ / ____ / ____

Tuberculin skin test read: ____ / ____ / ____ Result: _____mm (Record actual induration)

Interpretation (based on mm. of induration as well as risk factors): Positive ____ Negative ____

- If results are positive, refer to the Health Department.
- If you have been treated for TB you must bring a clearance from your medical doctor.

Signature of HCP _____