Fairfield University

Undergraduate Student Medical Report

This medical report in its entirety is to be mailed to:
Student Health Center, Dolan Hall, Fairfield University, 1073 North Benson Road, Fairfield, CT 06824-5195
(Please keep a copy for your personal records)

This page to be completed by the student (required).

ID _____

Name _____ Gender _____ Date of Birth _____

Address _____ Home Phone No. _____
Street

_____ Student Cell Phone No. _____
City State Zip

Emergency Contacts

Father's Name or Guardian's	Home Phone	Cell Phone	Work Phone	Occupation
Mother's Name or Guardian's	Home Phone	Cell Phone	Work Phone	Occupation

CONSENT

I HEREBY GIVE CONSENT FOR MY (MINOR CHILD) (SELF) TO RECEIVE ROUTINE CARE THROUGH THE FAIRFIELD UNIVERSITY STUDENT HEALTH CENTER.

Signature of Parent or Guardian _____ Date _____ Signature of Student _____ Date _____

Student Health Insurance & Waiver
Fairfield University requires all full-time undergraduate students to subscribe to a health insurance policy. Students are automatically enrolled and billed for the University-sponsored plan. Students who have comparable health insurance coverage and do not wish to be enrolled in the University-sponsored plan must complete an online waiver to provide proof of coverage. For more information go to **www.fairfield.edu/healthcenter**

PERSONAL HEALTH HISTORY

MEDICAL OR HEALTH CONCERNS — Please check conditions/diseases you have had. If NONE apply, check this box. ☐

	Absent/Irregular Periods		Cancer		High Blood Pressure		Rheumatic Fever
	Acne		Celiac Disease		H.I.V.		Seizure Disorder/ Epilepsy
	Anemia		Depression		Kidney Disease		Sexually Transmitted Disease
	Anxiety		Diabetes Mellitus		Liver Disease		Skin Problem
	Arthritis		Eating Disorder		Migraine Headaches		Substance Use Disorder
	Asthma		Fainting (Frequent)		Mononucleosis		Substance Use Disorder: In Recovery
	Attention Deficit Disorder		Fracture (Specify)		Obsessive Compulsive Disorder		Surgery (Specify)
	Autistic Spectrum Disorder		Gastroesophageal Reflux Disease		Painful Periods		Thyroid Disease
	Back Problem		Head Injury/Concussion		Pneumonia		Urinary Tract Infection (Recurrent)
	Bipolar Disorder		Hearing Impairment		Polycystic Ovarian Syndrome		Visual Impairment
	Bowel Problem		Heart Problem		Pregnancy		

Please explain any checked boxes: _____

This page to be completed by the student (required).

ALLERGIES: ☐ YES ☐ NO

Drug Allergy (specify): _____ Type of Reaction: _____

Food* Allergy (specify): _____ Type of Reaction: _____

Environmental/Other Allergies (specify): _____ Type of Reaction: _____

* Students with food allergies are directed to **www.fairfield.edu/foodallergies.**
This web-page has important information and additional forms which need to be completed.

MEDICATIONS:

Are you currently taking medication? (Include over the counter, vitamins/supplements, birth control pills.)

Please list below:

Medication Name	Dose	Frequency

Chronic or long-term, ongoing medical condition? (**Please have physician write a medical summary and attach to this form**.)

_____

List date(s) and reason(s) for any hospitalizations.

_____

Have you had emotional or psychological problems? Describe type of treatment (e.g., hospitalizations, psychotherapy and/or medications.)

_____

Any additional health information you would like to add:

_____

_____

_____

_____

FAMILY HISTORY

Name	Age	Medical Conditions/ Health Concerns	Cause of Death	Age at Death/ Year of Death
Father				
Mother				
Siblings				
Children				

This page to be completed by your Healthcare Provider (recommended but not required).

PHYSICAL EXAMINATION

Date of Physical Exam _____

Height _____ Weight _____ BP _____ / _____ Pulse _____

Vision: Rt 20/_____ Lt 20/ _____ Glasses: Rt 20/_____ Lt 20/ _____

Hearing: Rt _____ Lt _____

General Development	Normal	Abnormal	Explanation
Skin			
Eyes			
Ears			
Nose			
Throat			
Teeth			
Neck			
Thyroid			
Chest			
Heart			
Abdomen			
External Genitalia			
Hernia			
Pelvic			
Rectal			
Neurological			
Musculoskeletal			

Urinalysis: Date _____ Results _____

Hgb or Hct_____ Date_____

Allergies _____

Medications _____

Additional comments and recommendations: _____

_____

_____

_____

Signature of Health Care Provider Date

Print Name _____

Office Address_____

Office Phone No. _____

This page to be completed by your Healthcare Provider.

MMR (Measles, Mumps and Rubella) Immunizations/Immunity (required by state law):

MMR Vaccine Date#1 ____/_____/_____ MMR Vaccine Date#2 _____/_____/_____

OR attach copy of MMR titer results OR attach certificate of disease from a physician

Varicella (Chickenpox) Immunizations/Immunity (required by state law):

Vaccine Date#1 _____/_____/_____ Vaccine Date#2 _____/_____/_____

OR attach copy of Varicella titer results OR Date of disease _____/_____/_____

Quadrivalent Meningococcal Conjugate Immunization (required by state law): Must be within the 5 years prior to starting classes

Menactra® ☐ *Menveo*® ☐ (minimum 1 dose required)

Vaccine Date #1 _____/_____/_____ Vaccine Date #2 _____/_____/_____

Recommended Immunizations (not required):

Tetanus Vaccine Date _____/_____/_____ Td ☐ Tdap ☐ Updated within 10 years

Hepatitis B Series Date#1_____/_____/_____ Date#2 _____/_____/_____ Date#3_____/_____/_____

Serogroup B Meningococcal Vaccine (students ages 16-23) Recommended, not required

Bexsero®	OR	*Trumenba*®
Date#1____/_____/____ #2 ____/____/____		Date#1____/____/____ #2 ____/____/____ #3 ____/____/____

Tuberculosis (TB) Screening (required):

PART I: To be completed by student and reviewed by health care provider:

Country of Birth: _____

Have you ever had a positive tuberculosis skin or blood test in the past? Yes ☐ No ☐

Have you ever had close contact with persons known or suspected to have active TB disease? Yes ☐ No ☐

Were you born in a country that has a high incidence of active TB disease (see Appendix A, page 6)? Yes ☐ No ☐

Have you had frequent or prolonged visits* to one or more of the countries listed in Appendix A? Yes ☐ No ☐

Have you been a resident, employee, or volunteer in a high risk congregate setting (e.g. correctional facilities, homeless shelters, high risk health care facilities)? Yes ☐ No ☐

Do you have a health condition (listed in Appendix B) which suppresses your immune system? Yes ☐ No ☐

If the answer is YES to any of the above questions, TB testing (as outlined in Part II) is required. Continue to Part II.

If the answer is **NO** to all of the above questions no further testing or action is required. You may stop here.

_____

Signature of Health Care Provider Date

Print Name _____

Address _____ Phone No. _____

*The significance of the exposure should be discussed with a health care provider and evaluated.

Reviewed by SHC RN: Initials_____ Date_____

Part II Tuberculosis (TB) Screening:

Clinical Assessment by the Health Care Provider: Clinicians should review and verify the information in Part I. Only persons answering YES to any of the questions in Part I are candidates for either Mantoux Tuberculin Skin Test or Interferon Gamma Release Assay (IGRA), (unless a previous positive test has been documented).

Does this student have a history of positive TB skin test or IGRA blood test? Yes ☐ No ☐

(If YES, document below)

Does this student have a history of BCG vaccination? (If yes, consider IGRA, if possible) Yes ☐ No ☐

(A history of BCG vaccination does not preclude testing of a member of a high risk group.)

1. Does the student have signs and symptoms of active tuberculosis disease? Yes ☐ No ☐

If NO (and student is high risk for TB), proceed to #2 or #3.
If YES, proceed with evaluation to exclude active TB disease including TST, chest X-ray and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

TST result should be recorded in mm of induration, transverse diameter, if no induration, write "0".
See Appendix C for interpretation guidelines.

Date given: _____/_____/_____

Date read: _____/_____/_____ Result _____ mm induration

Interpretation: Positive ☐ Negative ☐

3. Interferon Gamma Release Assay (IGRA)

Date obtained: _____/_____/_____

Result: Positive ☐ Negative ☐

4. Chest X-Ray (Required if TST or IGRA is positive):

Date of Chest X-Ray: _____/_____/_____

Results: Normal ☐ Abnormal ☐ (Report to Health Dept. if abnormal chest X-Ray)

PART III Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest X-Ray should receive a recommendation to be treated for latent TB with appropriate medication.

Student agrees to receive treatment. ☐

Student declines treatment at this time. ☐

This student has completed TB treatment ☐ List medication(s) and dates of treatment:

Medication(s): _____ Dates of treatment:_____

_____

Signature of Health Care Provider Date

Print Name _____

Address _____ Phone No. _____

Appendix A: List of high[1] risk TB countries. Circle country or countries identified in part I of TB screening:

Afghanistan
Albania
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
eSwatini
Ethiopia
Fiji
French-Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Appendix B: Health Conditions causing immune suppression:

- HIV/AIDS
- Organ Transplant recipient
- Immunosuppressed persons:
  e.g. taking > 15mg/day of prednisone for >1 month; immunosuppressive therapy (TNF-α antagonist, cancer chemotherapy)

Appendix C: TST Interpretation Guidelines:

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TBdisease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

[1] Incidence rate of ≥ 20/100,000
Data available at: www.who.int/tb/country/data/profiles/en/