Franciscan University of Steubenville
Confidential Health Record Form
Student Health Services

OFFICE USE ONLY

Fall 2019: _____

Spring 2020: _____

Student ID: _____

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.

University Wellness Center, Franciscan University of Steubenville
1235 University Blvd. • Steubenville, OH 43952-1763
740-284-7223 • Fax: 740-284-7036

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/Other Allergies: _____

4. List any prescribed medications: _____

_____

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	Depression	❑ Y ❑ N	Recurrent ear infections	❑ Y ❑ N	Thyroid problem	❑ Y ❑ N
Anxiety/panic attacks	❑ Y ❑ N	Heart problem	❑ Y ❑ N	Recurrent sinusitis	❑ Y ❑ N	Tobacco use	❑ Y ❑ N
Anorexia/bulimia	❑ Y ❑ N	Hepatitis/jaundice	❑ Y ❑ N	Rheumatic fever	❑ Y ❑ N	Transplant	❑ Y ❑ N
Blood disorder	❑ Y ❑ N	High blood pressure	❑ Y ❑ N	Seizures/convulsions	❑ Y ❑ N	Tuberculosis	❑ Y ❑ N
Chicken pox	❑ Y ❑ N	Migraines	❑ Y ❑ N	STDs	❑ Y ❑ N	Urinary tract infections	❑ Y ❑ N
Diabetes	❑ Y ❑ N	Pneumonia	❑ Y ❑ N	Stomach/bowel problem	❑ 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:

_____

_____

Complete both sides.

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.

(DTP/DTaP) (DT) ____ /____/ ____
___ /____/____
___ / ___ /____
___ /____/____
M D YR

Measles/Mumps/Rubella ____ /____ /___
____ /____ / __
M D YR

Haemophilus Influenzae B ____ /____/ ____
___ /____/____
___ / ___ /____
___ /____/____
M D YR

Hepatitis A ____ /____ /___
____ /____ / __
M D YR

Td or Tdap ____ /____ /___
M D YR

Polio ___ /____/____
___ / ___ /____
___ / ___ /____
M D YR

Varicella (Chicken Pox) ____ /____ /___
____ /____ / __
M D YR

Date of Varicella ____ /____ /___
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 Ohio Revised Code 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 ❑ Y ❑ N

_____ /_____ / _____
_____ /_____ / _____
M D YR

Hepatitis B vaccine received ❑ Y ❑ N

_____ /_____ / _____
_____ /_____ / _____
_____ /_____ / _____
M D YR

If No, you 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
Signature of Parent/Guardian Student

for such diagnostic, therapeutic, and operative procedures deemed necessary for my child.

_____ _____
Signature of Parent/Guardian Date