



HEALTH FORM

Required of Students Living in University Housing

Name _____ SID _____
Last First MI Preferred Name

Date of Birth ___/___/___ Female Male

Medical Insurance Company _____ Group No. _____

Policy No. _____ Precertification required? No Yes (____) _____

In case of emergency, notify _____
Name Relationship to student

Home Phone (____) _____ Alternate Phone (____) _____

**TAPE
PICTURE
HERE**

Authorization and Consent

By signature, I verify that the information provided on this form is true. I hereby agree that Samford University Student Health Services may evaluate and treat all injuries or illnesses for which help is sought as deemed necessary by duly licensed personnel, including immunizations and therapeutic procedures. In the case of a minor student (under the age of 19), this treatment may proceed without prior notification of the undersigned parent or guardian.

Student Signature _____ Date _____

Signature of minor's parent/guardian _____

**PHYSICAL EXAMINATION
(must be within the last 12 months)**

Age	Wt.	Ht.	Pulse	B/P	Urinalysis	Hemoglobin OR Hematocrit
					Alb Glucose Blood	
Contact Lenses yes no		Visual Acuity: OD 20/		Corrected Uncorrected		
Glasses yes no		OS 20/				

PLEASE EXAMINE AND COMMENT ON THE FOLLOWING SYSTEMS

	Normal	Abnormal	Remarks or additional information
Head, Eyes, Ears, Nose and Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Hernia			
Musculoskeletal			
Neuropsychiatric			
Skin			
Metabolic/Endocrine			
Organ loss or impairment			

Drug Allergies _____ Current Medications _____

Medical History _____

Surgical History _____

Is the patient currently under treatment for any medical or emotional condition? No Yes If so, please comment below.

MD/PA/NP/RN Signature _____ Date _____

Print Name _____ Phone (____) _____

Address _____

**COMPLETE AND RETURN TO Student Health Services, Samford University, 800 Lakeshore Drive, Birmingham, AL 35229.
Keep a copy for your records.**



IMMUNIZATION RECORD

Required of all students

Name _____ SID _____

Last First MI Preferred Name

Address _____

Street City State ZIP

Date of Birth ____/____/____ Female Male Cell Phone (____) _____

Enrolling Year _____ Fall Jan Term Spring Summer

M.M.R. (Measles, Mumps and Rubella)

(No immunization required if born before 1957)

M.M.R. (Measles, Mumps, Rubella)	#1 _____ month/ day/ year	#2 _____ month/day/year
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OR

MEASLES (Rubeola) two doses required OR positive immune titer*

MUMPS one dose required OR report of positive immune titer*

RUBELLA one dose required OR report of positive immune titer*

Measles	#1 _____ month/day/year	#2 _____ month/day/year	Titer results and date *attach report copy
Mumps	#1 _____ month/day/year	Titer result and date *attach report copy	
Rubella	#1 _____ month/day/year	Titer result and date *attach report copy	

TETANUS-DIPHTHERIA PERTUSIS

Vaccination must be within the last 10 years

Tdap _____ month/day/year	OR	Td _____ month/day/year
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TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease? Yes No **If no**, proceed to 2.

If yes, proceed with additional evaluation to exclude active tuberculosis disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group* or is the student entering a health profession? Yes No **If no**, stop. **If yes**, proceed to 3.

3. PPD Skin Test (Mantoux) within the last 12 months

Date Given _____ Date Read _____ Results (mm induration) _____ **If positive**, proceed to 4.
month/day/year month/day/year

4. Chest x-ray (required if PPD is positive) Date _____ Normal Abnormal

*High-risk students include those who have arrived within the past 5 years from any country EXCEPT Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

REQUIRED OF ALL FRESHMEN LIVING ON CAMPUS

VARICELLA (Chickenpox)

Date of Disease	_____ month/year	
OR Immunization	#1 _____ month/day/year	#2 _____ month/day/year

MENINGOCOCCAL

Immunization	_____ month/day/year
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REQUIRED OF ALL PHARMACY, NURSING AND ATHLETIC TRAINING STUDENTS (Recommended for all students)

HEPATITIS B vaccination or titer

#1 _____ month/day/year	#2 _____ month/day/year	#3 _____ month/day/year
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OR

Hepatitis B Surface Antibody	_____ month/day/year	Reactive Nonreactive
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THIS RECORD MUST BE SIGNED BY A HEALTH-CARE PROVIDER (Health Department stamp is acceptable)

MD/PA/NP/RN Signature _____ Date _____

Print Name _____ Phone (____) _____

Address _____

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