

Questions?

740.587.6200
www.denison.edu/student-affairs/
handbook/health.html

Return to:

Health Services
Denison University
PO Box 810
Granville, OH 43023-0810
FAX: 740.587.6758

The goal of the Health Service is to provide high quality medical care to you during your years at Denison. In order to establish your health file with our facility, we ask that you read the following information and carefully observe the requirements and deadlines concerning the health inventory form. Additional information about our services is found in the section of this notebook marked "Other Campus Offices."

If you have any history of a chronic disease or illness, please submit documentation from your health providers addressing your diagnosis and treatment plan. This information is essential for your safety and well being, as well as continuity of care, should you have any medical needs that arise while you are residing within our Denison community.

TO THE STUDENT:

Call now to arrange an appointment with your health care provider. Documentation must be submitted by July 8th.

HEALTH HISTORY, PHYSICAL EXAMINATION AND IMMUNIZATIONS

Every entering student is required by the University to complete the health inventory, submit documentation of a current physical examination and provide a record of immunizations as listed in this letter. Students are required to submit these records to Health Services. All records are kept confidentially secure. The physical exam must have been done within the 12 months prior to your arrival on our campus in the fall. You may download and print this form at: www.denison.edu/academics/firstyear or you may prefer to use the copy in this notebook. (NCAA regulations require participants in any sport to have an additional pre-participation physical examination by a university health care provider after the athlete arrives on campus. Your coach will advise you of the date and time of that exam soon after you arrive.)

Your immunization records must be filed with the Health Services office by July 6th in order to avoid interruption of your class registration process and to obtain the key to your residence hall room when you arrive on campus. The immunization policy is designed to safeguard the health of our campus community by requiring documentation of the following with month, day and year each was given:

REQUIRED

- Measles, mumps and rubella vaccinations. It is required the you have received two (2) doses of measles (MMR or rubeola-containing) vaccine after you were 12 months of age, prior to arriving at Denison
- TB (Intradermal Tuberculin test) done within the last 12 months if you answer "yes" to any of the TB screening questions on page 23.

The University also requests dates of the basic DPT series, most recent tetanus booster and polio vaccine series. Although these immunizations are not required for admission, it is information that the student will need if travel is part of their Denison experience. Hepatitis B series and meningococcal meningitis vaccines are recommended, not required. However, Ohio law requires a declaration of status regarding these two vaccines for all students residing in residential housing.

IMPORTANT!

Take this page, page 24 & page 25 of the health inventory form with you to your appointment. Be sure the health care provider reads this information.

TO THE HEALTH CARE PROVIDER:

The health and immunization policy at Denison University states that all entering students are required to complete and return the five (5) page health inventory to Health Services by the July 8th deadline. Failure to meet the deadline will cause interruption in the student's eligibility to complete the class registration process and to live on campus. Your cooperation is requested in helping the student meet this obligation.

If your patient has a history of chronic disease or ongoing illness, please be sure to include documentation from your office or the specialist involved, concerning the diagnosis and treatment plan. This documentation is vital in order to provide continuity of care, should your patient have any ongoing medical needs or exacerbations of the disease/illness while residing within the Denison community.

Requirements:

- A physical examination within the 12 months prior to student's arrival on our campus in the fall. This exam must be signed by the provider. We prefer that you use our form.
- Documentation of two (2) rubeola-containing vaccinations after 12 months of age.
- TB (Intradermal Tuberculin test) done within the last 12 months if the student answers "yes" to any of the TB screening questions on page 23.

We can provide better continuity of care if the student will allow you to release any pertinent information regarding ongoing health issues. If you think this is appropriate, please suggest your patient sign the release at the time of the visit. Please either mail to:

Health Services
Attn: Medical Director
Denison University
Box 810
Granville, OH 43023-0810
or
FAX to 740-587-6758



DENISON UNIVERSITY HEALTH RECORD

HEALTH INVENTORY

Deadline: July 8, 2009

Questions?

740.587.6200

www.denison.edu/student-affairs/handbook/health.html

Return to:

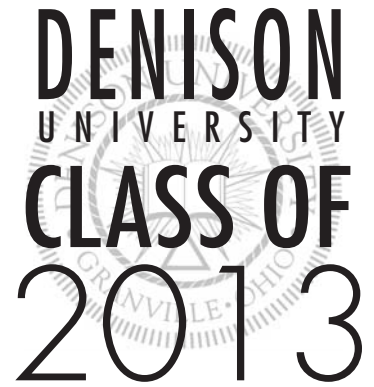
Health Services

Denison University

PO Box 810

Granville, OH 43023-0810

FAX: 740.587.6758



Name _____
last first middle preferred name

Address _____
street city state zip

Date of Birth ____/____/____
month day year Home Phone _____

Cell Phone _____

Gender _____ Email _____

PERSONAL PHYSICIAN _____ PHONE _____

ALLERGIES:

To medication? NO ___ YES ___
list names

To food? NO ___ YES ___
list names

To bee or wasp sting? NO ___ YES ___ Seasonal allergies? NO ___ YES ___

If on allergy desensitization injections, please have your physician send detailed instructions for continuing the desensitization while at Denison.

STATEMENT OF AUTHORIZATION

I authorize Denison University's Health Center to administer medical and surgical services and immunizations to me, to perform emergency procedures as necessary, and to refer me to duly licensed medical personnel when indicated (including transfer to outside medical facilities) at the discretion of the university physician.

I hereby state that I am capable of safely participating in vigorous physical activity offered through physical education, intramural and intercollegiate athletics unless otherwise noted in this health inventory.

Emergency contact # 1: Name _____ Relationship _____
Home: _____ Cell: _____ Work: _____

Emergency contact #2: Name _____ Relationship _____
Home: _____ Cell: _____ Work: _____

Signature of student if over 18

Signature of parent or guardian if under 18
(Legal age of adulthood in Ohio)

Without my written consent, information in my medical file is not available to anyone outside Health Services. Though Denison's Health and Counseling Services are separate offices, the provision of seamless medical and counseling services may necessitate a collaborative approach between the two offices. I, therefore, give authorization to the treating professionals in Health Services and Counseling Services to release pertinent information to each other for the co-management of my care. This authorization can be revoked by me in writing at any time.

Signature of the student if over 18

Signature of parent or guardian if under 18
(Legal age of adulthood in Ohio)

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSAGE (include oral contraceptives and over-the-counter medications)

NOTICE: All information presented is confidential and will not be released to anyone outside Health Services. This includes Faculty and Administration.

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING?

	YES	NO		YES	NO
1. Alcoholism/chemical dependency	_____	_____	23. Seizure disorder	_____	_____
2. Anemia/blood disease	_____	_____	24. Psychiatric treatment	_____	_____
3. Asthma/exercise induced asthma	_____	_____	25. Psychological problem/counseling	_____	_____
4. Bone/joint disease	_____	_____	26. Suicide attempt	_____	_____
5. Cancer	_____	_____	27. Pneumonia	_____	_____
6. Chickenpox	_____	_____	28. Premenstrual syndrome	_____	_____
7. Chronic disease of any kind	_____	_____	29. Pregnancy	_____	_____
8. Concussion/Unconsciousness	_____	_____	30. Abortion	_____	_____
9. Diabetes	_____	_____	31. Painful menstruation	_____	_____
10. Drug/Alcohol overdose	_____	_____	32. Obesity	_____	_____
11. Ear disease	_____	_____	33. Rheumatic fever	_____	_____
12. Eating disorder	_____	_____	34. Skin disease or acne	_____	_____
13. Eye disease	_____	_____	35. Stomach trouble	_____	_____
14. Any sexually transmitted disease	_____	_____	36. Intestinal disease	_____	_____
15. Frequent headaches	_____	_____	37. Tonsillitis	_____	_____
16. Heart disease	_____	_____	38. Blood transfusion	_____	_____
17. High blood pressure	_____	_____	39. Other serious illness	_____	_____
18. Hepatitis	_____	_____	40. Other medical problem	_____	_____
19. Kidney disease	_____	_____	41. Disabilities	_____	_____
20. Major trauma/multiple injuries	_____	_____	42. Hospitalization/surgery	_____	_____
21. Meningitis	_____	_____	43. Unexplained weight change	_____	_____
22. Mononucleosis	_____	_____			

Explanation of all yes answers: _____

ALL STUDENTS COMPLETE

FAMILY HISTORY

Among your BLOOD relatives, is there a history of the following?

	Yes	No	Relationship
High blood pressure	_____	_____	_____
Heart attack before age 50	_____	_____	_____
Diabetes	_____	_____	_____
Cancer	_____	_____	_____
Kidney disease	_____	_____	_____
Depression	_____	_____	_____
Alcoholism or chemical dependency	_____	_____	_____
Tuberculosis	_____	_____	_____
Eating disorder	_____	_____	_____
Sickle cell anemia	_____	_____	_____
Suicide	_____	_____	_____

TO INSURE CONFIDENTIALITY, RETURN THIS COMPLETED FORM TO THE HEALTH CENTER. THANK YOU.

NOTICE: All information presented is confidential and will not be released to anyone outside Health Services. This includes Faculty and Administration.

HEALTH-WELLNESS BEHAVIORS

- | YES | NO | |
|-------|-------|--|
| _____ | _____ | 1. Do you smoke?
If yes, how many? _____ cigarettes/cigars/pipe per day for _____ years? |
| _____ | _____ | 2. Do you chew tobacco or snuff? |
| _____ | _____ | 3. Has it been longer than 1 week since you have exercised?
3.a. If you do exercise, how often? _____ |
| _____ | _____ | 4. Do you get fewer than 7–8 hours of sleep a night? |
| _____ | _____ | 5. Do you view sleep as a luxury as opposed to a necessity? |
| _____ | _____ | 6. Do you skip meals or eat without consideration of the nutritional value of foods? |
| _____ | _____ | 7. Do you drink alcohol? If yes, please answer the following questions:
7.a. Have you ever felt you should cut down on your drinking?
7.b. Do you sometimes feel annoyed by people criticizing your drinking?
7.c. Have you ever felt bad or guilty about your drinking?
7.d. Do you, at times, drink more than you intend to? |
| _____ | _____ | 8. Do you use recreational drugs? |
| _____ | _____ | 9. Do you have concerns about your own or a friend’s drug use? |
| _____ | _____ | 10. If sexually active, are you careless about birth control? |
| _____ | _____ | 11. If sexually active, have you ever engaged in any genital contact behaviors without the use of a condom? |
| _____ | _____ | 12. If sexually active, have you ever had more than one partner in your lifetime? |
| _____ | _____ | 13. FEMALES—Has it been more than one month since you’ve performed a self breast exam?
13.a. Do you have any questions about how to perform a self breast exam? |
| _____ | _____ | 14. MALES—Has it been more than one month since you’ve performed a testicular self exam?
14.a. Do you have any questions about how to perform a testicular self exam? |
| _____ | _____ | 15. Do you have concerns about your weight? |
| _____ | _____ | 16. Has it been more than a month since you’ve done a self skin exam? |
| _____ | _____ | 17. Do you have questions about your risk for developing skin cancer and how to decrease that risk? |
| _____ | _____ | 18. Do you use a tanning bed or sunbathe frequently? |
| _____ | _____ | 19. Do you skip regular dental exams? |
| _____ | _____ | 20. Do you ever ride in a vehicle without your seat belt fastened? |
| _____ | _____ | 21. Do you ride a bicycle without wearing a helmet? |
| _____ | _____ | 22. Do you have firearms in your car or home? |
| _____ | _____ | 23. Do you have concerns about your ability to handle stress? |
| _____ | _____ | 24. Do you feel sad or depressed frequently? |
| _____ | _____ | 25. Have you had difficulty establishing or maintaining close friendships? |
| _____ | _____ | 26. Have you been dissatisfied with your ability to handle interpersonal conflict? |
| _____ | _____ | 27. Are you living in a place without a smoke detector? |
| _____ | _____ | 28. Are you regularly disappointed with the emotional support from your family? |

Please list people living in your household: _____

COMPLETE THIS SECTION ONLY IF PARTICIPATING IN INTERCOLLEGIATE ATHLETIC PROGRAMS.

- | YES | NO | |
|-------|-------|--|
| _____ | _____ | Have you ever passed out during or after exercise? |
| _____ | _____ | Have you ever had chest pain during or after exercise? |
| _____ | _____ | Do you have a heart murmur? |
| _____ | _____ | Have you ever had heart palpitations? |
| _____ | _____ | Have you ever had shortness of breath during or after exercise? |
| _____ | _____ | Did you ever cough during or after exercise? |
| _____ | _____ | Do you have nausea, vomiting, black or tarry bowel movements? |
| _____ | _____ | Do you have sickle cell anemia or sickle cell trait? |
| _____ | _____ | Are you missing a paired organ? (eye, kidney, testicle) |
| _____ | _____ | Have you ever had a seizure? |
| _____ | _____ | Have you ever had a stinger , burner, or numbness in arm? |
| _____ | _____ | Have you ever had a serious injury to your genitals? |
| _____ | _____ | Have you had a recent weight loss? |
| _____ | _____ | Do you use any special equipment? |
| _____ | _____ | Do you wear contact lenses? |
| _____ | _____ | Do you wear dental appliances? (bridge, braces, cap, plate) |
| _____ | _____ | Has any physician ever withheld or denied clearance for participation? |

A PHYSICAL EXAM IS REQUIRED FOR ADMISSION TO DENISON UNIVERSITY. VARSITY ATHLETES WILL COMPLETE ADDITIONAL HISTORY AND UNDERGO FURTHER EVALUATION BY DENISON TEAM PHYSICIANS

Tuberculosis (TB) Screening Questionnaire

To be completed by incoming students

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?

Were you born in one of the countries *listed below* and arrived in the U.S. within the past 5 years?

* (If yes please CIRCLE the country)

Have you ever traveled** to or in one or more of the countries listed below? (If yes, please CIRCLE the country/ies)

Have you ever been vaccinated with BCG?

* future CDC updates may eliminate the 5 year time frame

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

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

HEALTH CARE PROVIDER PHYSICAL EXAMINATION- *Completed by provider office only*

Please review the attached health history as filled in by the student and parent.

Student Name _____ Date of Exam _____

Date of Birth ____ / ____ / ____ Height ____ / ____ Weight ____
month day year feet inches

NOTICE:
 If Student answered yes to any TB screening questions DENISON requires the completion of a Tuberculin Skin test (Mantoux)

BLOOD PRESSURE _____ PULSE RATE _____ RESPIRATION RATE _____

	NORM	ABN	N.E.	COMMENTS	IMPRESSIONS
Head					
Eyes					
ENT					
Teeth					
Neck (incl. thyroid)					RECOMMENDATIONS Are there any limitations for this student's participation in a full program of physical activity including competitive athletics? <input type="checkbox"/> YES <input type="checkbox"/> NO List limitations _____ _____ _____
Chest & Lungs					
Heart					
Abdomen					
Genitalia (incl. hernia)					
Pelvic (if indicated)					
Rectal (if indicated)					
Spine					
Extremities & Joints					
Neurologic					
Skin					
Emotional status					

