

# Health Services

## Questions?

740-587-6200

## Locate forms:

[www.denison.edu/offices/health](http://www.denison.edu/offices/health)

[www.denison.edu/academics/firstyear](http://www.denison.edu/academics/firstyear)

## Return to:

Health Services

Denison University

PO Box 810

Granville, OH 43023-0810

FAX: 740-587-6758

DENISON  
UNIVERSITY  
CLASS OF  
2016

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. General information about our services is found in the "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 2nd.

### 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. Please use the enclosed health history forms or you may prefer to download and print this form at: [www.denison.edu/academics/firstyear](http://www.denison.edu/academics/firstyear). (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 2nd 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 that 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 7.

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!

Answer the questions at the top of page 7 and then take this page, page 7 and page 8 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 2nd 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.





# Health Record / Health Inventory

**Deadline: July 2, 2012**

**Questions?**

740-587-6200

**Locate forms:**

www.denison.edu/offices/health

www.denison.edu/academics/firstyear

**Return to:**

Health Services

Denison University

PO Box 810

Granville, OH 43023-0810

FAX: 740-587-6758

# DENISON UNIVERSITY CLASS OF 2016

**PLEASE PRINT CLEARLY**

Name \_\_\_\_\_  
last first middle preferred name

Address \_\_\_\_\_  
street city state zip

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Home Phone \_\_\_\_\_  
month day year 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 (specify below)	___	___
4. Bone/joint disease	___	___	26. Suicide attempt	___	___
5. Cancer	___	___	27. Pneumonia	___	___
6. Chickenpox	___	___	28. Premenstrual syndrome	___	___
7. Chronic disease (specify below)	___	___	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 (specify below)	___	___
15. Diagnosed migraines	___	___	37. Tonsillitis/frequent or chronic	___	___
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	___	___	44. Sinusitis/frequent or chronic	___	___

Explanation of all yes answers: \_\_\_\_\_

---



---

**ALL STUDENTS COMPLETE**

**FAMILY HISTORY**

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

	<u>Yes</u>	<u>No</u>	<u>Relationship</u>
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**

- | <u>YES</u> | <u>NO</u> |  |
|------------|-----------|--|
| _____      | _____     | 1. Do you smoke?<br>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?<br>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:<br>7a. Have you ever felt you should cut down on your drinking?<br>7b. Do you sometimes feel annoyed by people criticizing your drinking?<br>7c. Have you ever felt bad or guilty about your drinking?<br>7d. 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?<br>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?<br>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.**

- | <u>YES</u> | <u>NO</u> |  |
|------------|-----------|--|
| _____      | _____     | 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 COMPLETED WITHIN THE PAST 12 MONTHS IS REQUIRED FOR ALL STUDENTS ADMITTED TO DENISON UNIVERSITY.**

**VARSITY ATHLETES UNDERGO FURTHER EVALUATION BY DENISON TEAM PHYSICIANS DURING A SPORTS PHYSICAL. THIS EXAM WILL TAKE PLACE ONCE THE STUDENT/ATHLETE IS ON CAMPUS**

**Questions?**

740-587-6200

**Locate forms:**[www.denison.edu/offices/health](http://www.denison.edu/offices/health)[www.denison.edu/academics/firstyear](http://www.denison.edu/academics/firstyear)**Return to:**

Health Services

Denison University

PO Box 810

Granville, OH 43023-0810

FAX: 740-587-6758

**Medical Conditions That May Affect Room Assignment:**

Please check if you believe that you will need a living environment that can accommodate a disability or medical condition for you or a family member's special physical need. Examples of such accommodations may include: first floor room; to live in close proximity to a kitchen and/or bathroom; to have an air conditioning unit in your room. In order to request a special accommodation, you must submit this form, along with supporting documentation, to the Health Center no later than July 2, 2012. You may also locate these forms at the addresses listed below. Requests must include physician's written documentation including date of diagnosis, severity of diagnosis, current treatment plan and how a requested housing accommodation fits with the treatment plan. If you have a chronic disease or condition it is strongly advised that you supply supporting medical records to provide continuity of care.

---

Medical/Chronic Illness

[http://www.denison.edu/academics/support/verif\\_med\\_disability.pdf](http://www.denison.edu/academics/support/verif_med_disability.pdf)

---

Psych

[http://www.denison.edu/academics/support/verif\\_psych\\_disability.pdf](http://www.denison.edu/academics/support/verif_psych_disability.pdf)

## Tuberculosis (TB) Screening Questionnaire

### To be completed by incoming student

**STUDENTS** Prior to visiting your Physician, 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?	<input type="checkbox"/>	<input type="checkbox"/>
Were you born in one of the countries <u>listed below</u> and arrived in the U.S. within the past 5 years? * (If yes please CIRCLE the country)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever traveled** to or in one or more of the countries listed below? (If yes, please CIRCLE the country/ies)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been vaccinated with BCG?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Must be completed within 12 months prior to students arrival on campus in the fall.  
Please review the attached health history as filled in by the student and parent.

**NOTICE:**

If Student answered yes to any TB screening questions above, **DENISON REQUIRES** the completion of a Tuberculin Skin test (Mantoux) done within the past 12 months prior to arriving on campus

Student Name \_\_\_\_\_ Date of Exam \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_/\_\_\_\_ Weight \_\_\_\_\_  
month day year feet inches

BLOOD PRESSURE \_\_\_\_\_ PULSE RATE \_\_\_\_\_ RESPIRATION RATE \_\_\_\_\_

	NORM	ABN	N.E.	COMMENTS	
Head					<b>IMPRESSIONS</b>
Eyes					
ENT					
Teeth					
Neck (incl. thyroid)					<b>RECOMMENDATIONS</b>
Chest & Lungs					
Heart					
Abdomen					
Genitalia (incl. hernia)					
Pelvic (if indicated)					
Rectal (if indicated)					
Spine					
Extremities & Joints					
Neurologic					
Skin					
Emotional status					

Are there any limitations for this student's participation in a full program of physical activity including competitive athletics?

YES  NO

List limitations \_\_\_\_\_

