Rice University - Student Health Data Form

Last Name_______________________________ First Name__________________Middle________________

Date of Birth____________Place of Birth_________________________Sex ( F  /  M ) Marital Status _______

Social Security# _________________Department (Graduate students)___________________________

Address___________________________________________________________________________________

State/Province________________    Country__________________   ZIP / Postal code________________

Telephone # __________________ E-mail________________________________

In Case of EMERGENCY , Please contact_______________________________ telephone#_______________

Relationship__________________

STUDENT ID #___________________________

IMPORTANT INSTRUCTIONS ABOUT THIS FORM

1. All undergraduate, graduate and MBA students must fully complete all sections (I, II, III, IV, and V) of this form.
2. All other classifications of students are only required to complete section V (meningococcal vaccination). (Please note that all students, regardless of classification, must comply with Texas State law regarding meningococcal vaccination, which is covered in section V of this form.)

3. The required section(s) of this form must be submitted to Student Health by the due date listed below. After the due date there is a $35 late fee.
   a. Fall Semester :
      a. undergraduates : June 1st
      b. graduate, MBA students, and other classifications: July 1st
   b. Spring Semester - all students: December 1st

4. Completed forms should be mailed to :

   RICE UNIVERSITY STUDENT HEALTH SERVICE
   6100 MAIN ST. MS#760
   HOUSTON, TX 77005    USA

5. Students under the age of 18 should include a notarized parental consent form, which is available on our website: health.rice.edu
6. Examining health practitioner must complete sections II - V

7. Failure to comply with University requirements regarding this form will prevent registration.

ADDITIONAL INFORMATION.
This form may be obtained online at http://health.rice.edu
Answers to frequently asked questions regarding this form may be found at the above web page.
Additional questions should be directed to hlsv@rice.edu, or (713) 348-4966

ME hold released
VA hold released
Missing / Needed data __________________

revised 11/2013
Section I. Health History (A) - please put a check mark in the box to indicate if there is a history of any of the following conditions. Note: the examining physician must comment fully on any checked response.

<table>
<thead>
<tr>
<th></th>
<th>Allergies / Hay Fever</th>
<th>Eye Disease or Injury</th>
<th>Mononucleosis (EBV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Anemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Anxiety</td>
<td>Gastrointestinal Disorder</td>
<td>Parasites</td>
</tr>
<tr>
<td>4</td>
<td>Arthritis</td>
<td>Heart Disease</td>
<td>Chicken Pox (Varicella)</td>
</tr>
<tr>
<td>5</td>
<td>Asthma</td>
<td>Heart Murmur</td>
<td>Measles (Rubeola)</td>
</tr>
<tr>
<td>6</td>
<td>Back or Neck Problems</td>
<td>Hepatitis</td>
<td>HIV</td>
</tr>
<tr>
<td>7</td>
<td>Bleeding or Clotting Disorders</td>
<td>High Blood Pressure</td>
<td>German Measles (Rubella)</td>
</tr>
<tr>
<td>8</td>
<td>Bone or Joint Problems</td>
<td>Hospitalization(s)</td>
<td>Typhoid Fever</td>
</tr>
<tr>
<td>9</td>
<td>Cancer</td>
<td>Inflammatory Bowel Disease</td>
<td>Cholera</td>
</tr>
<tr>
<td>10</td>
<td>Depression</td>
<td>Kidney Disease</td>
<td>Sickle Cell Disease or Trait</td>
</tr>
<tr>
<td>11</td>
<td>Diabetes</td>
<td>Malaria / Tropical Diseases</td>
<td>Sexually Transmitted Disease</td>
</tr>
<tr>
<td>12</td>
<td>Eating Disorder</td>
<td>Neurological Disease</td>
<td>Surgery (Any)</td>
</tr>
<tr>
<td>13</td>
<td>Disease of Mouth, Teeth, or Gums</td>
<td>Psychiatric Illness</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>33</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>35</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>42</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>43</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>44</td>
<td>Females only: Are your menstrual cycles...</td>
<td>Regular</td>
<td>Irregular (please comment)</td>
</tr>
</tbody>
</table>

(B) - Lifestyle Variables

Do you use tobacco? No Yes - If yes please indicate type and amount per day (week)__________________

Do you exercise? No Yes - If yes please indicate activity ______________________________

How many days per week? ______ Hours per week? ______

Do you drink alcohol? No Yes If yes please indicate amount and frequency__________________

Do you wear seat belts in the car? No Yes

Do you follow a specific diet or are there any dietary restrictions? No Yes - List _____________________________

Do you take any supplements or herbal medications? No Yes - List _____________________________

(C) - Family Medical History

Do any family members have any health problems or medical conditions? No Yes (please indicate)

The following sections are to be completed by the examining physician

To the examining physician, the student has already been accepted to Rice University. The information on this form will become part of the student’s confidential medical record maintained by the Student Health Service. Please fully complete Sections II, III, IV, and V

Section II. (A) - Please review the health history (sec. I (A) - above) and comment fully on all positive responses the student has indicated (attach separate sheet(s) if needed)
Section III. - Immunizations & Tuberculosis (TB) screening

Instructions
1. The medical professional must complete and sign section III (immunizations & TB screening), IV (physical examination) and V (meningococcal vaccination).
2. Section III includes A) required immunizations B) optional immunizations (recommended but not required) and C) required tuberculosis screening.
3. The student’s vaccination record should be attached but required responses must be recorded on this form.
4. Texas State Meningococcal Vaccination Requirement is covered in section V.

A.) Required Immunizations

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Requirements</th>
<th>Date of most recent vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria - Tetanus (d'T)</td>
<td>Must have completed primary series and received last booster within 10 years</td>
<td>Has patient completed primary series? □ Yes □ No (mm/dd/yr)</td>
</tr>
<tr>
<td>Mumps, Measles, and Rubella (MMR)</td>
<td>Must have received two vaccinations, OR submit blood antibody titers documenting immunity to these diseases (attach copy of lab results)</td>
<td>(mm/dd/yr) (mm/dd/yr)</td>
</tr>
<tr>
<td>Polio</td>
<td>Must have completed primary series</td>
<td>Has patient completed primary series? □ Yes □ No (mm/dd/yr)</td>
</tr>
</tbody>
</table>

B.) Optional Immunizations

Although the immunizations listed in this section are optional please note that they are recommended by the ACIP. Please indicate whether the student has been immunized and provide dates, as applicable.

1. Hepatitis B
   - □ no □ yes
   - Date 1 ______ Date 2 ______ Date 3 ______

2. Hepatitis A
   - □ no □ yes
   - Date 1 ______ Date 2 ______

3. Chicken Pox (Varicella)
   - □ no □ yes
   - Date 1 ______ Date 2 ______

4. HPV
   - □ no □ yes
   - human papilloma virus ______ ______ ______

Signature of medical professional verifying immunizations ___________________________ Date (M/D/Y) ___________________
C.) Required Tuberculosis (TB) Screening

Student: Last name __________________________ First name ____________________

Instructions (medical practitioner):
1. Screening must be done within 6 months prior to the first day of classes.
2. Please complete the TB risk assessment tool below by placing a checkmark in the appropriate boxes.
3. A student who has any positive risk factors (i.e., ‘yes’ response on any question) must be tested for TB infection unless there is written documentation of a previous positive tuberculosis skin test (TST) or interferon gamma release assay (IGRA) result. If there is written documentation of a previous positive result on TST or IGRA then a chest x-ray within 6 months prior to the first day of classes is required.
4. Note: prior immunization with BCG does NOT change TB screening requirements.

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>YES</th>
<th>NO</th>
<th>interpretative guidance ¶</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recent close or prolonged contact with someone with infectious TB disease</td>
<td></td>
<td></td>
<td>A</td>
</tr>
</tbody>
</table>
| 2. In the past 5 years have you lived or traveled (> 1 mo) anywhere other than the countries listed below
  Albania, Andorra, Antigua & Barbuda, Australia, Austria, Bahamas, Belgium, British Virgin Islands, Canada, Chile, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Granada, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Luxemborg, Malta, Netherlands, New Zealand, Norway, Oman, Puerto Rico, St. Kitts & Nevis, St. Lucia, Slovakia, Slovenia, Sweden, Switzerland, United Arab Emirates, United Kingdom, United States |     |    | B                         |
| 3. Chest radiographs with fibrotic changes suggesting inactive or past TB   |     |    | A                         |
| 4. HIV infection                                                            |     |    | A                         |
| 5. Organ transplant recipient                                               |     |    | A                         |
| 6. Immunosuppression secondary to use of prednisone (equivalent of >15 mg/day for >1 month) or other immunosuppressive medication such as TNF-α antagonists |     |    | A                         |
| 7. Injection drug user                                                      |     |    | B                         |
| 8. Resident or employee of high-risk congregate setting (e.g., prison, long term care facility, hospital, homeless shelter) |     |    | B                         |
| 9. Medical conditions associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck, Hodgkin’s disease, leukemia, and end-stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population]) |     |    | B                         |
| 10. Signs and symptoms of TB ? ∞                                            |     |    | complete evaluation needed |

If all of the responses above are negative (no) then no further TB testing is required
If any responses above are positive (yes) then either a TST or IGRA is required.
∞If the answer to item #10 is ‘yes’ then a complete evaluation for tuberculosis (e.g., chest x-ray, sputum cultures, etc.) is indicated

**TB skin test (PPD)**

- Date placed (M/D/Y) __________
- Date read (M/D/Y) __________
- mm induration: __________
- interpretation: □ positive □ negative
  - interpretative guidance from risk table above
  - >5 mm is positive with risk category A
  - >10 mm is positive with risk category B
  - >15 mm is positive with no known risk factors

If POSITIVE then a chest radiograph and management plan is required

**Interferon Gamma Release Assay Result**

- Date (M/D/Y) __________
- Specify method (circle one)
  - QFT-G
  - QFT-GIT
  - T-spot
  - other _____
- Result: □ positive □ negative

If POSITIVE then a chest radiograph and management plan is required

________________________
Signature of medical professional
Date (M/D/Y) __________
Section IV. Physical Examination

NAME _________________________________

Height _______  Weight _______  Body Mass Index \[
  \frac{\text{weight (kg)}}{\text{height (m)}^2}\]

  = _______  normal 18.5 - 25  obese >= 30

Blood Pressure _______  Pulse _______

Vision (uncorrected) - Right ___/____  Left ___/____  Both___/___

(with best correction) - Right ___/____  Left ___/____  Both___/___

System  Normal  Please comment on any abnormal findings

Eyes
Ears
Nose
Mouth / Throat
Dental
Neck
Respiratory
Heart
Peripheral pulses
Abdomen
Skin
Genito-urinary
Neurological
Emotional
Psychiatric
Back
Musculoskeletal

Please attach copies of any laboratory tests you feel are indicated

To the examining physician, Rice University is a rigorous, challenging academic institution. We ask that you consider how this might affect the student’s current state of health.

1. Does the student have any medical, emotional or psychiatric conditions that would interfere with functioning in a stressful environment? □ No  □ Yes

2. Does the student have any cardiovascular disease that would limit their full participation in sports? □ No  □ Yes

3. Are there any other conditions that would preclude physical training or competition in sports? □ No  □ Yes

4. Is the student currently being treated for any medical or psychiatric condition? □ No  □ Yes

5. Is the student underweight or overweight? □ No  □ Yes

If you answered yes to any question above please comment below. Attach or send a separate letter if needed

Name of examining *physician _________________________________  *note- must not be student’s parent
Address

______________________________
Signature

telephone #

Date ______________
Section V. - Meningococcal Vaccination

This section must be completed by all students regardless of classification

Last Name ____________________________First Name___________________________
Date of Birth (m/d/yr)_____________ Age____ Student ID# __________________
e-mail: __________________________ telephone#_________________

Instructions for section V

1. Fill out student name, student ID #, DOB, and contact information above.
2. Record the date of the most recent meningococcal immunization below and attach a copy of the immunization record.
3. Meningococcal vaccination must be within the past 5 years of the day classes will start.
4. All students, regardless of classification, must comply with Texas State law regarding meningococcal vaccination. Further information regarding this law may be found at http://www.dshs.state.tx.us/immunize/school/.
5. Students not in compliance with this section will not be able to register for classes. If delinquent beyond the first 10 days of classes the student will be withdrawn from enrollment.
6. Texas law allows for three types of waivers to the vaccination requirement --
   a. The student is 22 years of age or older
   b. Physician affidavit of harm / medical contraindication, or
   c. Exemption waiver for reasons of conscience (this must be filed with the Texas State Department of Health Services, and relevant documentation sent to Rice University Student Health).

Meningococcal vaccination
Quadrivalent vaccine (A,C,Y, W-135)

☐ Date of most recent vaccination (mm/dd/yr): ____________
   (Must be within 5 years of the first day of classes)

OR

☐ Exemption to vaccination (check appropriate box)
   ☐ a. The student is 22 years of age or older
   ☐ b. Physician affidavit of harm / medical contraindication (attach *)
   ☐ c. Exemption waiver filed with Texas State Dept of Health Services (attach *)

* appropriate documentation must be attached or the form is incomplete

Signature of Medical Professional __________________________
Printed name of Medical Professional _______________________
Date signed (M/D/Y) __________

COMPLETED FORMS SHOULD BE MAILED TO:

RICE UNIVERSITY STUDENT HEALTH SERVICE
6100 MAIN ST. MS#760
HOUSTON, TX 77005 USA

A list of frequently asked questions and additional information can be found on our website: health.rice.edu

e-mail: hlsv@rice.edu tele # (713) 348-4966 fax # (713) 348-5427