RICE UNIVERSITY HEALTH DATA FORM - Instructions (do **not** send this page)

Form

- All undergraduate, graduate, and MBA students must fully complete all sections of this form.
- Other classifications of students only need to submit the meningitis vaccination form. Please note that **all** students, regardless of classification, must comply with Texas State law regarding meningococcal vaccination.
- You MUST include your student ID number in order for us to process your form.
- Please note a student may not register for classes until this form is **completed**. The registration account hold will be released once ALL parts are complete.
- Once you have sent your form, you may check to see if it has been processed. Log into your ESTHER account to confirm. Your holds will be released within one week of receipt. The VA hold signifies need for proof of the meningitis vaccine, while the ME hold indicates an incomplete or missing health form . If your holds are released, you are clear. If not, please CALL our office at 713-348-4966 to find out what is missing.

Deadlines

- Undergraduates should submit their forms by June 1 for the fall or Dec 1 for the spring. You may certainly submit your forms after this, but your campus housing assignments will be delayed.
- Graduate students should submit forms by July 1 for the fall and Dec 1 for the spring.

Returning students

- If you are a RETURNING STUDENT and have been away from Rice for LESS than ONE YEAR, you may use your previous form. Please call to advise us of your choice and to confirm that your vaccines remain up to date.

Submission of the form

- Mail to Rice Student Health **6100 Main Street, MS 760 Houston, TX 77005**
- Graduate students must mail health forms to STUDENT HEALTH at the address above. Please do NOT mail to your department.
- If you are an International Student, you may email your form to HLSV@RICE.EDU
- Please note that privacy is not guaranteed in email and therefore mail is preferred. If you do email, it must be in a single PDF file and the file should be named with the student's first and last name. Students from the U.S.A. must mail forms to ensure privacy. Emailed forms from US students will not be accepted.

Physical exam and vaccine record

- Information from a physical exam performed in the PAST YEAR must be ENTERED on the form. A parent may not be the examining physician.
- If you have lost your vaccination records, you need to obtain boosters and provide documentation for Td (Tetanus-diphtheria), MMR (measles, mumps, rubella), and Meningococcal meningitis (ACWY). Your physician should document the loss and administer appropriate vaccinations. You may provide lab testing to indicate immunity.
- International students unable to obtain vaccines in their home countries may receive vaccines upon arrival in the United States. Your form will be clear once you submit your updated vaccines.
- If you have a medical condition or contraindication for a specific vaccination, your physician, who must be licensed in the United States, must submit an affidavit stating why the vaccination is medically contraindicated.
- Please have your doctor complete the vaccine section for required and recommended vaccines as we use these records when completing your travel abroad consults, internship or volunteer forms and employment physicals.

Meningitis Vaccine Requirement

- MENINGOCOCCAL vaccination (quadrivalent ACWY not the Meningitis B) must occur 10 days or more in advance of arrival on campus. If you had a single vaccination but it has been more than 5 years (using the date classes start), then you will need another vaccination. Students not in compliance will not be able to register for classes. If delinquent beyond the first 10 days of classes, the student will be withdrawn from enrollment.
- Further information on this Texas law is available at http://www.thecb.state.tx.us/index.cfm?objectid=A641CD0D-E56A-A36A-1BCB39FF80781178

  Texas law allows 3 types of waivers to the vaccination requirement:

  - The student is 22 years of age or older
  - Physician affidavit of harm/medical contraindication
  - Exemption waiver for reasons of conscience – must be filed with the Texas State Department of Health Services and documents sent to Rice University Student Health

Office Use Only MA ___ VE ___ Missing _____

RICE UNIVERSITY STUDENT HEALTH DATA FORM

Last name _____ First Name _____ Middle _____

Date of Birth _____ Place of Birth _____ Sex _____

Department (Graduate Students) _____ Entering year at Rice _____

☐ Undergraduate ☐ Graduate ☐ MBA Student ID _____

Address _____ City _____ State _____ Zip _____

Country _____ Telephone _____ E-mail _____

In Case of EMERGENCY, please contact _____ Telephone _____ Relationship _____

HEALTH HISTORY

Current Medical/Psychological Conditions: _____

_____

Surgeries _____

Current Medication(include supplements/herbal medications) _____

_____

Allergies DRUG _____

FOOD _____

INSECT _____ LATEX _____

PAST HISTORY – Circle if you have had any of these below (and physician should comment on any circled)

Allergies	Anemia	Anxiety	Arthritis	Asthma
Sickle cell disease or trait	Bleeding / clotting disorder	Bone/joint problems	German measles (Rubella)	Chicken Pox (varicella)
Inflammatory Bowel Disease	Gastrointestinal disorder	Diseases- mouth, teeth or gums	Eye disease or injury	Malaria/Tropical disease
Migraines	Headaches	Heart disease	Heart murmur	Neurological disease
Hypertension	Eating disorder	Kidney disease	Hepatitis	Diabetes
Psychiatric illness	Mononucleosis	Pneumonia	Parasites	Cholera
Measles (Rubeola)	HIV	Depression	Typhoid fever	Syphilis
Back problems	Cancer	Tuberculosis		

Do you use tobacco? ☐ If yes, type and amount per day _____

Do you drink alcohol? ☐ If yes, amount and frequency _____

Do any of your family members have any health problems? _____

PHYSICIANS - Please comment on any positive responses to the health history

_____

Name _____

PHYSICAL EXAM

HEIGHT _____ WEIGHT _____ Body Mass Index _____

BLOOD PRESSURE _____ PULSE _____

VISION right _____ left _____ both _____ (UNCORRECTED)

VISION right _____ left _____ both _____ (CORRECTED IF NEEDED)

SYSTEM	NORMAL	ABNORMAL
Eyes		
Ears		
Nose		
Mouth/Throat		
Dental		
Neck		
Respiratory		
Heart		
Abdomen		
Skin		
Neurological		
Psychiatric		
Musculoskeletal		

Physician please comment on any abnormalities _____

_____

_____

Does this student have any medical or psychiatric conditions that would interfere with functioning in a rigorous academic environment? _____

Does the student have any condition that would limit participation in sports? _____

Will the student need ongoing care with a specialist while in Houston and have arrangements been made for that? _____

_____

Name of examining physician _____ (may not be student's parent)

Address _____ City _____ State _____ Zip _____

Country _____ Telephone _____ E-mail _____

Signature of physician and date _____

Name _____

REQUIRED VACCINES

MENINGOCOCCAL VACCINATION – REQUIRED

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

Date of most recent vaccination – (m/d/y) _____ (must be within 5 years of the first day of classes)

OR

Exemption to vaccination (check appropriate box)

☐ Student is 22 years of age or older

☐ Physician affidavit of harm/medical contraindication-attach form from a physician licensed in the US

☐ Exemption waiver filed with Texas State Dept of Health Services (attach)

Signature of MEDICAL PROFESSIONAL _____

Printed name _____ Date _____

OTHER VACCINES REQUIRED

Diphtheria-Tetanus	Completed primary series – date (m/d/y) _____	Last dose (within past 10 years) (m/d/y) _____ Specify - ☐ Td or ☐ TdaP
Measles, Mumps, Rubella	Must have received 2 vaccines or submit titers to all 3	#1_____(m/d/y)#2_____(m/d/y) Or titers attached_____

RECOMMENDED VACCINES (not required)

Polio	Completed series – Yes or no	Date of most recent vaccine_____	
Meningitis B	Type_____	Dates_____	
Hepatitis B	#1_____	#2_____	#3_____
Hepatitis A	#1_____	#2_____	
Varicella (Chicken Pox)	#1_____	#2_____	
HPV(type _____)	#1_____	#2_____	#3_____

TRAVEL VACCINES (not required)

Yellow Fever	Date_____	
Typhoid	Oral or Injectable_____	Date_____

Signature of MEDICAL PROFESSIONAL _____

Printed name _____ Date _____

Name _____

TUBERCULOSIS SCREENING

QUESTION	YES	NO
Have you had tuberculosis or had a positive screening test (PPD,TB quantiferon, or t-spot)		
Have you had chest radiographs suggesting inactive or past TB?		
Have you had HIV, AIDS, diabetes, leukemia, lymphoma, an organ transplant or chronic immune disorder?		
Have you had a recent close contact with someone with TB?		
Have you had immunosuppression due to medication?		
Are you an injection drug (recreational not medical) user?		
Have you worked or volunteered in a high risk setting (prison, long term care facility, hospital, shelter)		
Do you have end stage renal disease, malabsorption syndrome, low body weight or have you had a gastrectomy?		
Do you have symptoms of TB (persistent cough, fever, night sweats, loss of appetite, weight loss)		
Were you BORN IN, LIVED IN or VISITED FOR MORE THAN ONE MONTH – Asia, Africa, South America, Central America, Mexico or Eastern Europe?		

If you answered **NO to all of the above questions, then you are finished**. If you answered **YES** to any of the above questions**, then your physician must complete the TB testing below**.

ATTENTION HEALTH CARE PROVIDER – If the patient answered YES to any of the above, then testing is required. Testing must be done **within 6 months** prior to the first day of classes. If a student has a history of positive testing, then a chest x-ray is required. History of BCG vaccination does not prevent testing.

PPD	Date placed _____	mm of induration _____
Or Quantiferon-TB or T-spot	Date of testing _____	Result (attach) _____

PPD Measurements:

≥ 5 mm	Positive for recent contacts with TB patients, abnormal chest x-rays suggesting TB, HIV/AIDS, Organ transplant patients, and immunosuppressed patients
≥ 10 mm	Positive for recent US immigrants (<5 years) from the areas listed above, injection drug users, employees/volunteers in high risk settings, or those with medical conditions associated with risk of progressing to TB disease if infected
≥ 15 mm	Positive for persons with no known risk factors for tuberculosis

If the PPD or Quantiferon testing is POSITIVE then a chest x-ray is REQUIRED (6 months prior to the start of class). Please attach the chest x-ray REPORT and the management plan including medication.

SIGNATURE OF MEDICAL PROFESSIONAL _____ DATE _____