

**FOR CLINIC USE**  
 ATTACH STUDENT INFORMATION LABEL

**HEALTH ASSESSMENT FORM**

**Instructions and Information – Important – Please Read!**

1. This form must be returned to the Student Health Service prior to arrival at the University. A completed Health Assessment and Immunization Record are required for enrollment.
2. All personal information should be filled out prior to visiting your Health Care Provider.
3. Both forms must be signed by a non-parental Health Care Provider.
4. This form will become a part of the Student Medical Record and will be treated as per our Privacy Notice.
5. The Student Health Service can perform physical examinations for incoming students during Orientation & Registration. Call 419-372-2271 for an appointment.

PLEASE TYPE OR PRINT

Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
last first middle include area code

Home Address \_\_\_\_\_  
Street City State Zip Code Country

Gender:  Male  Female Date of Birth (00/00/00) \_\_\_\_\_ BGSU ID# \_\_\_\_\_

Email address \_\_\_\_\_ Fax \_\_\_\_\_

Citizenship:  USA  Other—Specify \_\_\_\_\_

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ Phone: (H) \_\_\_\_\_ (W) \_\_\_\_\_

**PRIMARY PERSON TO NOTIFY IN CASE OF AN EMERGENCY (Parent/Guardian)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip Code Country

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Beeper \_\_\_\_\_

Fax \_\_\_\_\_ Email address \_\_\_\_\_

**DISABILITY**

If you consider yourself handicapped or disabled in any way please complete the following with specific information:

Psychological  Neurological  Hearing  Pulmonary  Learning  Mobility  Other \_\_\_\_\_

None of the above

Explain \_\_\_\_\_

**MEDICATIONS**

List all medications currently being taken with dosage, frequency and condition for which it is being taken:

MEDICATIONS	DOSAGE	FREQUENCY	DIAGNOSIS

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ BGSU ID# \_\_\_\_\_

**ALLERGIES**

Do you have allergies to any of the following? If so, describe reactions:

- Medications (please list) \_\_\_\_\_
- Anesthesia \_\_\_\_\_
- Foods \_\_\_\_\_
- Immunizations (please list) \_\_\_\_\_
- Insect Stings \_\_\_\_\_
- Environmental (pollen, etc.) \_\_\_\_\_
- Other \_\_\_\_\_
- Latex \_\_\_\_\_
- None Known

**PLEASE LIST ALL MEDICAL PROBLEMS, TREATMENTS AND DATES:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PLEASE LIST ALL PAST ACCIDENTS, OVERNIGHT HOSPITALIZATIONS AND SURGERIES (Please indicate dates.)**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you ever experienced sexual, physical and/or emotional abuse?  YES  NO

Have you had to interrupt school or work for an extended period of time due to physical, emotional or mental illness?  YES  NO

If yes, please explain \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

If any of your immediate family had/have the following, check the box indicating which family member it applies to:

	Father	Mother	Sibling	Grandparent		Father	Mother	Sibling	Grandparent
Alcohol/Drug Addiction					High Blood Pressure				
Cancer					Psychological Illness				
Diabetes					Died of heart disease under age 50				
Elevated Cholesterol					Stroke				
Heart Disease					Other				

Please comment on the health status of your immediate family, if known:

Family Member	Age	State of Health	Occupation (parents only)	Family Member	Age	State of Health
Father				Brother		
Mother				Sister		
Brother				Sister		
Brother				Sister		

**NOTICE OF PRIVACY PRACTICES**

With my signature below, I acknowledge receipt of the BGSU Student Health Service's Notice of Privacy Practices.

Student Name (Please PRINT) \_\_\_\_\_

STUDENT SIGNATURE

DATE

**PERMISSION FOR TREATMENT OF STUDENTS UNDER 18 YEARS OF AGE**

Ohio state law requires us to contact a parent or legal guardian **before** providing routine medical care to a minor. However, to avoid delay in treatment when emergent medical problems arise, we request that the following statement be signed by a parent or legal guardian. I hereby grant permission to the health care providers of Bowling Green State University Student Health Service to evaluate, treat, or secure a referral to an outside agency for my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of treatment plan or when needed for prevention of illness.

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE

RELATIONSHIP TO STUDENT

PHONE NUMBER (include area code)

**NOTE: To assist you, the Student Health Service is offering physical exams by appointment for incoming students during Orientation & Registration. Please call 419-372-2271 to schedule a physical.**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ BGSU ID# \_\_\_\_\_

**PHYSICAL EXAMINATION (Recommended within past 12 months.)**

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_

	NL	ABNL	COMMENTS
SKIN			
LYMPH			
EYES			
EARS			
NOSE			
MOUTH/THROAT			
NECK/THYROID			
BREASTS			
LUNGS			
HEART			
ABDOMEN			
BACK/SPINE			
GENITALIA			
EXTREMITIES			
NEUROLOGICAL			
OTHER			

Does this student have any injuries, disabilities, or congenital abnormalities?  YES  NO

EXPLAIN \_\_\_\_\_

Special Accommodations Needed?  YES  NO

EXPLAIN \_\_\_\_\_

**PROVIDER INFORMATION**

I have performed a physical examination on this patient within the past year. All medical/psychiatric conditions and therapies are noted above or on attached pages.

Date of Exam \_\_\_\_\_

Print Provider Name \_\_\_\_\_

Address (Please print or stamp) \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

\_\_\_\_\_  
SIGNATURE OF HEALTH CARE PROVIDER DEGREE

# BGSU IMMUNIZATION RECORD

Required by Ohio law and/or Bowling Green State University. Your signature is required in sections C & D.  
**Bowling Green State University Student Health Service**

Health Center Building • Bowling Green, OH 43403-0147 • Phone 419-372-2271 • Fax 419-372-8010 • www.bgsu.edu/health

**REQUIRED:**

Fill in dates. A non-parental health care provider **must** sign form. Serologic evidence of immunity is acceptable only when copies of laboratory reports are attached.

**A. M.M.R. (MEASLES, MUMPS, RUBELLA)**

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later #1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

2. Dose 2 given at 28 days after first dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

**B. TETANUS-DIPHTHERIA-PERTUSSIS**

Last tetanus-diphtheria booster \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

**OR**

Last Tetanus-Diphtheria-Pertussis booster \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

**C. Complete the MENINGITIS VACCINATION information below by checking the appropriate box.**

I have had the bacterial meningitis vaccine:  Menomune  
 Menactra

Date received \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

\_\_\_\_\_  
 STUDENT SIGNATURE DATE

\_\_\_\_\_  
 SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE  
 If student is under 18 years of age.

**D. Complete the HEPATITIS B information below by checking the appropriate box.**

I have had the hepatitis B vaccine.

#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

I have read, or have had explained to me, the information regarding hepatitis B. I understand the risks of not receiving the vaccine and have decided to decline vaccination at this time.

\_\_\_\_\_  
 STUDENT SIGNATURE DATE

\_\_\_\_\_  
 SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE  
 If student is under 18 years of age.

**RECOMMENDED:**

**E. POLIO**

Completed primary series of Polio immunizations \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr.

**F. HEPATITIS A**

#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr. Mo. Day Yr.

**G. CHICKENPOX (varicella) VACCINE**

#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr. Mo. Day Yr.

**H. HUMAN PAPILLOMAVIRUS (HPV) VACCINE**

(Three doses of vaccine for female college students 11-26 years of age at 0, 2 and 6-month intervals.)

#1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.

**I. TB SCREENING - REQUIRED**

1. Does the student have signs or symptoms of active TB?

YES  NO

If no, proceed to question 2.

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

2. Is the student a member of a high-risk group?  YES  NO  
 If no, STOP. No further evaluation is needed at this time.

If yes, administer tuberculin skin test (Mantoux only). A history of BCG vaccination should not preclude testing of a member of a high-risk group. If there is a history of a past positive PPD, proceed to question 4.

3. Tuberculin Skin Test (required within 1 year of enrollment if indicated by steps 1 and 2).

Date placed \_\_\_\_/\_\_\_\_/\_\_\_\_ Date read \_\_\_\_/\_\_\_\_/\_\_\_\_

Result \_\_\_\_\_ (Record actual mm of induration, transverse diameter; if no induration write "0")

Interpretation (based on mm of induration as well as risk factors):  Positive  Negative

4. Chest x-ray (required within 6 months of enrollment if tuberculin skin test is positive).

Result:  Normal  Abnormal Date of x-ray \_\_\_\_/\_\_\_\_/\_\_\_\_

**PROVIDER INFORMATION**

\_\_\_\_\_  
 Name of Health Care Provider (please print) Degree

\_\_\_\_\_  
 Signature of Provider

\_\_\_\_\_  
 Address (please print or stamp)

\_\_\_\_\_  
 Phone Fax

<sup>1</sup>Categories of high-risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. Prednisone 15 mg/d for 1 month) or other immunosuppressive disorders.



**MEDICAL/PRESCRIPTION INSURANCE INFORMATION REQUIRED**  
Bowling Green State University Student Health Service

PLEASE PRINT

**PATIENT INFORMATION**

Name (Last, First, Middle Initial)			Date of Birth	Sex
Local Telephone Number	Cell Number	Email Address	BGSU Student Identification Number	

Please provide us with a **COPY** of the front and back of any and all insurance cards that cover the patient listed above and mail to us along with the completed health assessment form in the enclosed envelope.

**PRIMARY MEDICAL INSURANCE INFORMATION**

Name of Policy Holder	Policy Holder's Date of Birth	Policy Holder's Phone Number
Policy Holder's Address		
Insurance Name	Claims Submission Address Ins. Co.	Ins. Co. Phone Number
Policy Holder's ID/Certificate #	Policy Holder's Group Number	Patient's Relationship to Card Holder <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Employer Name	Employer Address	Policy Holder's Social Security Number

**SECONDARY MEDICAL INSURANCE INFORMATION**

Name of Policy Holder	Policy Holder's Date of Birth	Policy Holder's Phone Number
Policy Holder's Address		
Insurance Name	Claims Submission Address Ins. Co.	Ins. Co. Phone Number
Policy Holder's ID/Certificate #	Policy Holder's Group Number	Patient's Relationship to Card Holder <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Employer Name	Employer Address	Policy Holder's Social Security Number

Please provide us with a **COPY** of both sides of your prescription insurance card. Your prescription insurance card may be different from your medical insurance card. If you have questions regarding prescription coverage please contact your insurance company.

**PRIMARY PRESCRIPTION INSURANCE INFORMATION**

Name of Policy Holder	Home Phone Number of Policy Holder	Work/Cell Number of Policy Holder
Prescription Insurance Company Name	Prescription Company Phone Number / BIN Number	Patient's Relationship to Card Holder <input type="checkbox"/> Child <input type="checkbox"/> Self <input type="checkbox"/> Spouse
Policy Holder ID/Member #	Prescription Card Group Number	Patient's Birth Order <input type="checkbox"/> 1st Child <input type="checkbox"/> 2nd Child <input type="checkbox"/> ____ Child

**Note: This form must be completed regardless of your insurance. This is NOT a waiver form for the Student Insurance Office and University-offered student insurance plan.**