



“A Choice to Change the World!”

**Division of Student Affairs
Department of Student Health Services**

Pre Entrance Health Record 2012

Please Complete in Ink or Type Only, Faxes or Copies will not be accepted.

Deadline for Submission

Fall Semester: June 1
Spring Semester: December 1

Return To:

Student Health Services
MacVicar Hall, Box 1683
Spelman College
350 Spelman Lane
Atlanta, Georgia 30314
(404) 270-5249

Congratulations on your acceptance to Spelman College! The Pre-Entrance Health Record is required before you are allowed to move in to campus housing and residence hall facilities as well as it is required for enrollment at Spelman College. The Pre-Entrance Health Record should be completed honestly and truthfully by you, your parents or guardian and your doctor. The pages and sections include the following:

- Demographic page – Should be completed by student, parent and or guardian.
- Allergies, screening for tuberculosis and other questions – Must be completed by physician or medical provider.
- Immunizations – This page should be completed by a physician or medical provider with any supporting immunization documentation. **Serology testing may be used if dates of immunization are unknown.**

ADDITIONAL INSTRUCTIONS FOR COMPLETING THIS RECORD:

- **FAXES OR COPIES ARE NOT ACCEPTABLE!**
- Each page must be completed in its entirety and submitted to **Student Health Services** by the deadline of **December 1, 2011 for the spring and June 1, 2012 for the fall.**
- All pages and all sections are required, along with signatures and office stamp of medical personnel completing the appropriate sections.
- **PLEASE DO NOT LEAVE ANY PAGES OR SECTIONS BLANK!** Incomplete pages and responses will result in the booklet being returned to you.
- **MAKE COPIES OF THIS BOOKLET FOR YOUR RECORDS!!!**

THIS FORM MUST BE COMPLETED BY A PHYSICIAN OR MEDICAL PROVIDER!

Name of Student: _____

Note: ALL ITEMS ARE REQUIRED.

- Allergies: Indicate if patient has allergies to medications and document the nature of the reaction.
- Obtain blood pressure, pulse, height and weight.
- Indicate if student is receiving care for a chronic illness or treatment for an emotional disorder.
- Perform the required screening for tuberculosis within the past 12 months of enrollment to Spelman College.
- Physician or medical provider should provide signatures and office stamp verifying completion of exam

ALLERGIES: Yes No, if yes to what? PCN Sulfa Erythromycin
 other _____

If yes, what is the nature of the reaction? _____

Blood Pressure _____ Pulse _____ Height _____ Weight _____

SCREENING FOR TUBERCULOSIS (Within the past 12 months)

The PPD skin test must be placed and read before the student will be allowed to move into campus housing. NOTE: If PPD is greater than 10mm induration, a chest x-ray must be obtained. If the chest x-ray is abnormal, INH treatment or other TB prophylaxis treatment should be initiated. *NOTE: PPD test should be mantoux within the past year (*tine or momovac not acceptable*).

	Date Placed	Date Read	Results
PPD*	_____	_____	_____

If positive, provide _____ mm induration (horizontal diameter) *Note: If greater than 10mm induration, chest X-ray required.*

X-Ray results: Normal Abnormal

If chest x-ray is abnormal, has patient begun INH treatment or other TB prophylaxis treatment? Yes No

If no, please explain _____

Received BCG: Yes No If yes, chest X-Ray required. X-Ray results: Normal Abnormal.

Has this individual had any surgical procedures? Yes No If yes, please explain _____

Please list all medications by name, dosage and purpose of medication including herbal and natural supplements:

Is this individual receiving care for any serious or chronic medical, emotional or behavioral conditions? i.e., (diabetes, hypertension, sickle cell anemia, anxiety, depression, eating disorders etc.) Yes No If yes, please explain _____

Are there any learning disabilities or learning challenges that require medication for management? Yes No If yes, please explain _____

Does this individual require special accommodations because of a documented medical condition? Yes No If yes, please contact the **Office of Disability Services to request special accommodations at (404) 270-5289.**

PHYSICIAN OR MEDICAL PROVIDER SIGNATURE

PHYSICIAN/PA/NP _____
 Name (Please Print) _____ Signature _____

Telephone Number (include area code) _____ Date Exam Completed _____

IMMUNIZATION RECORD

Name of Student: _____

Please note: All immunizations and/or lab/serology tests are required unless otherwise noted. This record must be completed by your physician or medical provider. All immunizations must be verified by the signature and office stamp of your physician or medical provider below. This record must be in ENGLISH. You may submit copies of immunization records and lab/serology test as proof of vaccine, history of disease or immunity.

PLEASE MAKE COPIES OF THIS RECORD FOR YOUR RECORDS!!

REQUIRED VACCINES

MONTH/DAY/YEAR

- A. **MENACTRA VACCINE A/C/Y/3-135) (REQUIRED)**
VACCINE AGAINST NEISERRIA MENINGITIS
 _____/_____/_____

- B. **VARICELLA VACCINE (2 doses required)**
VACCINE AGAINST CHICKENPOX DISEASE
 First vaccine (Required) _____/_____/_____
 Second vaccine (Required) _____/_____/_____
Other Means of Obtaining Proof of Immunity
 Student had disease (chickenpox or shingles confirmed by MD's records) _____/_____/_____
 Laboratory/serology test for evidence of immunity: _____/_____/_____
[Obtain if uncertain about dates of vaccine disease]
 Reactive Non-Reactive
Note: if the test is NON-REACTIVE, You MUST receive the Varicella vaccines

- C. **HEPATITIS VACCINE (3 doses required)**
VACCINE AGAINST HEPATITIS B DISEASE
 First vaccine (Required) _____/_____/_____
 Second vaccine (Required) _____/_____/_____
 Third vaccine _____/_____/_____
Other Means of Obtaining Proof of Immunity
 Laboratory/serology test for Hepatitis B surface antigen antibody: _____/_____/_____
[Obtain if uncertain about dates of your Hepatitis B vaccines]
 Reactive Non-Reactive
Note: if the test is NON-REACTIVE, you must receive the Hepatitis B vaccines.

- D. **M.M.R. (2 doses required)**
VACCINE AGAINST MEASLES, MUMPS AND RUBELLA
 First vaccine (Required) _____/_____/_____
 Second vaccine (Required) _____/_____/_____
 Student born before 1957 is considered immune. <Date of Birth> _____/_____/_____
Other Means of Obtaining Proof of Immunity
 Laboratory/serology test for evidence of immunity: _____/_____/_____
[Obtain if uncertain about dates of vaccine or disease]
 Reactive Non-Reactive
Note: if the test is NON-REACTIVE, You MUST receive the MMR vaccines.

- E. **TETANUS, DIPHTHERIA (Tdap) or (Td)**
VACCINE TO PREVENT "LOCKJAW"
 Tetanus/diphtheria containing booster dose within the last 10 years. _____/_____/_____

HEALTH CARE PROVIDER

Please stamp with office stamp to verify you have reviewed and or administered any or all immunizations!

[Office Stamp Here]

Provider _____
 Name (please print) _____ Signature and Title _____