

Student's Name _____ ID or SS# _____
 Date of Birth _____ Winthrop Entrance Date _____

IMMUNIZATION REQUIREMENT

MUST BE COMPLETED AND SIGNED BY STUDENT:

1A. Tuberculosis Screening Questionnaire

1) Have you lived in , traveled to or had household visitors from Asia, Africa, South America, Central America, the Caribbean, Eastern Europe, or the former Soviet Union within the past 5 years)?	Yes	No
2) Have you experienced persistent cough, unexplained fever, night sweats, weight loss, bloody sputum (mucus)?	Yes	No
3) Have you had close contact with person(s) known to have or suspected of having Tuberculosis?	Yes	No
4) Have you worked/volunteered in or been a resident of a long-term care facility, nursing home, homeless shelter, correctional institution, hospital or other health care facility, or residential facility for persons with AIDS?	Yes	No
5) Do you have any of the following conditions: diabetes, renal failure or dialysis, leukemia or lymphoma, other cancer, immunosuppressive therapy (including prednisone >15 mg./day for 1 month), silicosis, low body weight, gastrectomy, gastric bypass, jejunioileal bypass, HIV infection, injection drug use?	Yes	No

STUDENT SIGNATURE _____ **Date:** ____/____/____

1B. If you answered Yes to any of the above questions, you must have further assessment by a Healthcare Provider. You will need a TB Skin Test unless you have had a positive TB Skin Test in the past. If you had a positive TB skin test in the past and answered Yes to #2 above, you must get a chest x-ray. Please send written documentation of previous positive test and any x-rays, treatment reports or evaluations related to the positive test.

TB SKIN TEST (if indicated):

PPD 0.1ml ID L or R forearm Placed by: _____ Date placed: ____/____/____
 TB Test result: _____ mm. induration Neg./ Pos. Date read: ____/____/____

Signature of health care professional reading test _____

If TB test is positive, **CHEST X-RAY** must be obtained. **Send written report.** Date of X-ray: ____/____/____ Report attached: Yes

TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER:

2. REQUIRED IMMUNIZATIONS:

Proof of immunization or immunity is required of all students. **Form must be signed by your Health Care Provider or Health Dept.,** or a copy of an official certificate (such as from the military or Health Dept.) must be enclosed. All pages must have your name, date of birth and ID number on them. **Do not send until all items are complete including, if indicated, TB test with result recorded and signed, and chest x-ray report. Incomplete forms will be returned to you.**

2A. MMR (Measles (Rubeola), Mumps, Rubella): 2 doses (or the equivalent) required. Doses given before first birthday are not valid. Persons born before 1957 are exempt from this requirement. Proof of immunity may also be provided by blood test.

MMR #1 Dose given after 1967 and after 1st birthday Date: ____/____/____

MMR #2 Dose given at least 28 days after Dose #1 Date: ____/____/____

OR

Immune Titers: Attach Lab Reports Date: ____/____/____

2B. TETANUS-DIPHTHERIA: Booster within the last 10 years required.

Tdap - Date: ____/____/____ **OR** **Td**- Date: ____/____/____

3. Recommended but not Mandatory:

***HEPATITIS B:** A serious viral liver infection, preventable by vaccine. See web page for more information.

Hepatitis B: 3 doses #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

***MENINGITIS:** A rare but serious, sometimes fatal, bacterial infection that may be prevented by vaccination; recommended by the CDC and the American College Health Association for college freshman living in residence halls. See our web page for more information (www.winthrop.edu/hcs/healthservices-home.htm)

Menactra (MCV4) Date: ____/____/____ **OR** **Menomune (MPSV4)** Date: ____/____/____

Signature of Health Care Provider _____ Date _____

Print Name of Health Care Provider _____

Address _____

Street _____ City _____ State _____ Zip _____

Telephone _____ Fax _____

NOTE: This form will be retained by Health Services for 10 years, then destroyed. Please make a copy of this form before mailing original.

MAIL THIS FORM TO: Winthrop University, Division of Student Life, Health Services, 217 Crawford Bldg. Rock Hill, SC 29733

Student's Name _____ ID or SS# _____

Date of Birth _____ Winthrop Entrance Date _____

MEDICAL HISTORY
To be completed by Student

ALLERGIES: Medications _____

Other (food, insects, environmental/seasonal, etc) _____

CURRENT MEDICATIONS: _____

*Please check below if you have now, or have had in the past, any of the following conditions.
Please indicate dates if possible and give details on the lines provided below.*

- | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Chicken Pox
<input type="checkbox"/> German Measles (Rubella)
<input type="checkbox"/> Measles
<input type="checkbox"/> Mumps
<input type="checkbox"/> Infectious Mononucleosis
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Anemia
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma
<input type="checkbox"/> Exercise-induced Asthma
<input type="checkbox"/> Shortness of Breath with exercise
<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Recurrent Bronchitis
<input type="checkbox"/> Recurrent Ear Infection
<input type="checkbox"/> Cardiac:
<input type="checkbox"/> Marfan's Syndrome
<input type="checkbox"/> Congenital Condition
<input type="checkbox"/> Murmur
<input type="checkbox"/> Rheumatic Heart Disease
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Chest Pain or Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Other: Specify _____
<input type="checkbox"/> Disability:
<input type="checkbox"/> Vision
<input type="checkbox"/> Hearing
<input type="checkbox"/> Mobility
<input type="checkbox"/> ADHD
<input type="checkbox"/> Learning
<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Chronic Medical Illness
<input type="checkbox"/> Other, Explain _____ | <input type="checkbox"/> Emotional Disorder:
<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Drug/Alcohol Dependency/Abuse
<input type="checkbox"/> Depression
<input type="checkbox"/> Panic/Anxiety Disorder
<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Mood Disorder
<input type="checkbox"/> Obsessive Compulsive Disorder
<input type="checkbox"/> Thoughts of hurting oneself
<input type="checkbox"/> Hospitalized for Emotional Disorder
<input type="checkbox"/> Other, explain _____
<input type="checkbox"/> Trouble sleeping
<input type="checkbox"/> Bone Fractures
<input type="checkbox"/> Joint Injury
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Back Pain/Problems
<input type="checkbox"/> Osgood-Schlatter
<input type="checkbox"/> Other Musculoskeletal Disorders
<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Head Injury with loss of Consciousness
<input type="checkbox"/> Concussion
<input type="checkbox"/> Fainting/Dizziness
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Recurrent Sinusitis
<input type="checkbox"/> Recurrent Nosebleeds
<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Hearing Loss
<input type="checkbox"/> Speech Defects
<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> Syncope or Fainting with Exercise
<input type="checkbox"/> Tension Headaches
<input type="checkbox"/> Ulcer
<input type="checkbox"/> Inflammatory Bowel Syndrome
<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Reflux
<input type="checkbox"/> Rectal Bleeding
<input type="checkbox"/> Hernia
<input type="checkbox"/> Recurrent Bladder Infection
<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Kidney Infection
<input type="checkbox"/> Chronic Kidney Disease
<input type="checkbox"/> Sexually Transmitted Infection
<input type="checkbox"/> Pelvic/Vaginal Infections
<input type="checkbox"/> Testicular Lump
<input type="checkbox"/> Testicular Torsion
Menstrual History
<input type="checkbox"/> <i>painful periods</i>
<input type="checkbox"/> <i>heavy flow</i>
<input type="checkbox"/> <i>irregular periods</i>
<input type="checkbox"/> <i>Age at 1st period</i> _____
<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Eczema
<input type="checkbox"/> Hives
<input type="checkbox"/> Acne
<input type="checkbox"/> Chronic Rash
<input type="checkbox"/> Heat Related Illness
<input type="checkbox"/> Serious Accident/Injury
<input type="checkbox"/> Surgeries: _____

<input type="checkbox"/> Other: _____

Do you use tobacco?
<input type="checkbox"/> Yes <input type="checkbox"/> No _____ pks/day
Do you drink alcohol?
<input type="checkbox"/> Yes <input type="checkbox"/> No _____ amt/week |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

Explanation for any answers above: _____

Family History

	Age	State of Health	Occup	Age at Death	Cause of Death
Father					
Mother					
Brother					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	Relationship		Yes	Relationship
Alcoholism			Stomach Disease		
Tuberculosis			Mental Illness		
Arthritis			Sudden Death from		
Asthma, Hay Fever			Non-Traumatic Causes		
Diabetes			Marfan's Syndrome		
Epilepsy, Convulsions			Cancer		
Heart Disease			Type		
High Blood Pressure			Are you adopted	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I hereby certify that the above information is complete and accurate.

SIGNATURE _____ **DATE** _____

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PHYSICAL EXAMINATION
To be completed by Health Care Provider

BP _____ P _____ R _____ T _____ Ht _____ Wt _____ lbs.

Visual Acuity: OD _____ OS _____ OU _____ Corrected Hearing: (whisper) _____

LMP DATE ___/___/___ LAST TETANUS DATE ___/___/___ TOBACCO: Y/N ___ pack/day x ___ years ETOH: Y/N Quantity _____

ALLERGIES: _____

CURRENT MEDICATIONS: _____

SIGNIFICANT PAST MEDICAL HISTORY: _____

PHYSICAL EXAM	Normal	Abnormal	Comments
1. Skin			
2. Head, Ears, Eyes, Nose, Throat			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Lungs, Chest			
6. Breasts			
7. Heart			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities/Musculoskeletal			
12. Neurologic			
13. Emotional/Psychological			
14. Other Findings			
15. Disabilities			

LABS: Hgb or Hct _____ Urinalysis _____

Recommendation for physical activities, including participation in club, intramural & intercollegiate sports:
 Unlimited Limited If Limited, please explain: _____

Signature of Health Care Provider _____ Date _____

Print Name of Health Care Provider _____

Address _____

Street _____ City _____ State _____ Zip _____

Telephone _____ Fax _____

WINTHROP UNIVERSITY
 Division of Student Life – Health Services
 217 Crawford Building • Rock Hill SC 29733
 Phone: 803/323-2206 • FAX: 803/323-3332