Oregon State University

Name: _____

Student ID Number: _____

Complete and return to:
Student Health Services Immunization Office
110 Plageman Building
Corvallis, OR 97331-8567
Phone: 541-737-7573
Medical Fax: 541-737-9665
Email: immunizations@oregonstate.edu
Note: Email is not a secure form of communication

STUDENT HEALTH HISTORY

What is your preferred name? _____

Please check your legal sex: ☐ female ☐ male

Please check your gender: ☐ female ☐ male ☐ transgender ☐ other: _____

Please check your preferred pronoun: ☐ she ☐ he ☐ other: _____

Please note: This medical history form will not be reviewed until you come to Student Health Services (SHS) for care. Please call to speak to a nurse or clinician to address any concerns or special needs.

Check any health issues you have now or have had in the past:

- ☐ Visual impairment (not correctable)
- ☐ Hearing impairment
- ☐ Physical disability
- ☐ Autism
- ☐ ADHD/ADD
- ☐ Learning disability (not ADHD)
- ☐ Seasonal allergies
- ☐ Eczema
- ☐ Asthma
- ☐ Pneumonia
- ☐ Heart attack
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Palpitations/Arrhythmia
- ☐ Congenital heart defect
- ☐ Stroke
- ☐ Clotting disorder/DVT or Thrombosis
- ☐ Bleeding disorder
- ☐ Sickle Cell disease
- ☐ Thalassemia
- ☐ Migraine headaches
- ☐ Seizures
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Thyroid problem
- ☐ Polycystic Ovarian Syndrome
- ☐ Chronic kidney disease
- ☐ Kidney infection
- ☐ Celiac disease
- ☐ Crohn's disease
- ☐ Ulcerative colitis
- ☐ Liver disease
- ☐ Rheumatoid arthritis
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Other chronic pain condition
- ☐ Tuberculosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV/AIDS
- ☐ Chlamydia
- ☐ Gonorrhea
- ☐ Genital Herpes
- ☐ Alcoholism or alcohol abuse
- ☐ Substance addiction or abuse
- ☐ Eating disorder
- ☐ Anxiety/Panic attacks
- ☐ Depression
- ☐ Obsessive Compulsive Disorder (OCD)
- ☐ Bipolar Disorder
- ☐ History of suicide attempt
- ☐ Post-traumatic Stress Disorder (PTSD)
- ☐ Schizophrenia

If you complete this form electronically, please rename it and save before printing.

Have you ever been diagnosed with cancer? **Check one:** ☐ **No** ☐ **Yes**

If yes, what type(s)?:

_____

Do you have any other medical conditions or injuries not listed above? **Check one:** ☐ **No** ☐ **Yes**

If yes, please list:

_____

Have you ever had a surgery (for example wisdom teeth removed, tonsillectomy, appendectomy, hernia repair, fracture or joint repair)? **Check one:** ☐ **No** ☐ **Yes**

If yes, please list:

_____

Do you have any allergies to medication? **Check one:** ☐ **No** ☐ **Yes**

If yes, list name(s) of medication and type of reaction:

_____

Have you ever had an anaphylactic or severe allergic reaction to anything other than a medication?
Check one: ☐ **No** ☐ **Yes**

If yes, list allergy(s) and type(s) of reaction: _____

Check any health problems your biological parents, grandparents or siblings have had, if known.

If you are adopted or you do not know your biological family medical history, please ☐ **check here**

☐ Blood clots	☐ Diabetes	☐ Mental health problems
☐ Stroke	☐ Kidney disease	☐ Colon cancer
☐ Heart disease/Heart attack	☐ Thyroid disorder	☐ Melanoma
☐ High blood pressure	☐ Drug or alcohol addiction	☐ Breast cancer
☐ High cholesterol	☐ Suicide or suicide attempt	☐ Ovarian cancer

Are there any other hereditary health problems that run in your family not listed above? **Check one:** ☐ **No** ☐ **Yes**

If yes, please list: _____

AUTHORIZATION FOR EMERGENCY CONTACT: Please contact the person named in the emergency contact section below if I am being hospitalized or treated for any emergency or life-threatening medical or psychological condition and am unable to contact them myself.

Emergency Contact:

Name: _____ Relationship: _____

Address: _____

Mobile phone: _____ Other phone: _____

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Immunization Information

Please list all dates in the month/day/year format (mm/dd/yyyy)

REQUIRED VACCINES

MMR (Measles, Mumps, and Rubella combined): Two (2) doses REQUIRED OR Two (2) doses of Measles, two (2) doses of Mumps, and one (1) dose of Rubella REQUIRED Lab tests (titers) may be substituted as proof of immunity in place of vaccinations.	Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ OR **Measles** Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ **Mumps** Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ **Rubella** Dose 1 _____ _____ _____
Hepatitis B ☐ Engerix - B or Recombivax HB (3 doses required) ☐ Heplisav - B (2 doses required) ☐ TwinRix - A/B (2 doses required) Lab tests (titers) may be substituted as proof of immunity in place of vaccinations OR indicate date of disease	Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ Dose 3 _____ OR **Date of disease** _____ _____ _____
Tdap (Tetanus, Diphtheria, Pertussis): One (1) dose since 2005 REQUIRED	Dose 1 _____ _____ _____
Varicella (Chicken Pox): Two (2) doses REQUIRED Lab tests (titers) may be substituted as proof of immunity in place of vaccinations. OR Indicate date of disease	Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ OR **Date of disease** _____ _____ _____
Meningococcal (MCV4 or MenACWY) REQUIRED of all students under the age of 22. Must have received one (1) dose since turning age 16 (Menactra®, Menveo®, Menomune®).	Dose 1 _____ _____ _____
Meningococcal B Two (2) doses of Bexsero® or three (3) doses of Trumenba® REQUIRED of all students under age 26. This is NOT the same as Meningococcal MCV4 or MenACWY above.	**Bexsero®** Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ OR **Trumenba®** Dose 1 _____ _____ _____ Dose 2 _____ _____ _____ Dose 3 _____

Immunization Information
(continued)

RECOMMENDED VACCINES	**Human Papillomavirus** (HPV) Gardasil® or Gardasil®-9	Dose 1_____ _____ _____ Dose 2_____ _____ _____ Dose 3_____
	Hepatitis A (Disregard if Hepatitis A&B (TwinRix®), listed above)	Dose 1_____ _____ _____ Dose 2_____ _____ _____

Exemptions:

☐ I was born before January 1, 1957 (automatic exemption from MMR and Varicella requirement).

☐ All students requesting a medical or non-medical waiver must come to Student Health Services in person to meet with a nurse or clinician before signing the waiver (must be done within the first three weeks of your first term).

☐ I have attached a copy of my immunization documentation ☐ I have attached a copy of my titer results

Signature of person completing form *(Parent, Student or Health Care Provider):*

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Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

1. Have you ever had close contact with persons known or suspected to have active TB disease?
   ☐ Yes ☐ No

2. Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please select the country below)
   ☐ Yes ☐ No

- ☐ Afghanistan
- ☐ Algeria
- ☐ Angola
- ☐ Anguilla
- ☐ Argentina
- ☐ Armenia
- ☐ Azerbaijan
- ☐ Bahrain
- ☐ Bahamas
- ☐ Bangladesh
- ☐ Belarus
- ☐ Belize
- ☐ Benin
- ☐ Bhutan
- ☐ Bolivia (Plurinational State of)
- ☐ Bosnia and Herzegovina
- ☐ Botswana
- ☐ Brazil
- ☐ Brunei Darussalam
- ☐ Bulgaria
- ☐ Burkina Faso
- ☐ Burundi
- ☐ Cambodia
- ☐ Cameroon
- ☐ Cape Verde
- ☐ Central African Republic
- ☐ Chad
- ☐ China
- ☐ China, Hong Kong SAR
- ☐ China, Macao SAR
- ☐ Colombia
- ☐ Comoros
- ☐ Congo
- ☐ Côte d'Ivoire
- ☐ Dem People's Republic of Korea
- ☐ Democratic Republic of Congo
- ☐ Djibouti
- ☐ Dominican Republic
- ☐ Ecuador
- ☐ El Salvador
- ☐ Equatorial Guinea
- ☐ Eritrea
- ☐ Ethiopia
- ☐ Fiji
- ☐ French Polynesia
- ☐ Gabon
- ☐ Gambia
- ☐ Georgia
- ☐ Ghana
- ☐ Greenland
- ☐ Guam
- ☐ Guatemala
- ☐ Guinea
- ☐ Guinea-Bissau
- ☐ Guyana
- ☐ Haiti
- ☐ Honduras
- ☐ India
- ☐ Indonesia
- ☐ Iraq
- ☐ Kazakhstan
- ☐ Kenya
- ☐ Kiribati
- ☐ Korea (Republic of)
- ☐ Kuwait
- ☐ Kyrgyzstan
- ☐ Lao People's Dem Rep
- ☐ Latvia
- ☐ Lesotho
- ☐ Liberia
- ☐ Libya
- ☐ Lithuania
- ☐ Madagascar
- ☐ Malawi
- ☐ Malaysia
- ☐ Maldives
- ☐ Mali
- ☐ Marshall Islands
- ☐ Mauritania
- ☐ Mauritius
- ☐ Mexico
- ☐ Micronesia (Federated States of)
- ☐ Moldova (Republic of)
- ☐ Mongolia
- ☐ Morocco
- ☐ Mozambique
- ☐ Myanmar
- ☐ Namibia
- ☐ Naura
- ☐ Nepal
- ☐ Nicaragua
- ☐ Niger
- ☐ Nigeria
- ☐ Niue
- ☐ Northern Mariana Islands
- ☐ Pakistan
- ☐ Palau
- ☐ Panama
- ☐ Papua New Guinea
- ☐ Paraguay
- ☐ Peru
- ☐ Philippines
- ☐ Portugal
- ☐ Qatar
- ☐ Republic of Korea
- ☐ Republic of Moldova
- ☐ Romania
- ☐ Russian Federation
- ☐ Rwanda
- ☐ Sao Tome and Principe
- ☐ Senegal
- ☐ Sierra Leone
- ☐ Singapore
- ☐ Solomon Islands
- ☐ Somalia
- ☐ South Africa
- ☐ South Sudan
- ☐ Sri Lanka
- ☐ Sudan
- ☐ Suriname
- ☐ Swaziland
- ☐ Syria (Syrian Arab Republic
- ☐ Taiwan
- ☐ Tajikistan
- ☐ Tanzania
- ☐ Thailand
- ☐ Timor-Leste
- ☐ Togo
- ☐ Tunisia
- ☐ Turkey
- ☐ Turkmenistan
- ☐ Tuvalu
- ☐ Uganda
- ☐ Ukraine
- ☐ United Republic of Tanzania
- ☐ Uruguay
- ☐ Uzbekistan
- ☐ Vanuatu
- ☐ Venezuela (Bolivarian Republic)
- ☐ Viet Nam
- ☐ Yemen
- ☐ Zambia
- ☐ Zimbabwe

Source: World Health Organization estimates of tuberculosis incidence by country, 2016. Countries with rates of ≥20 cases per 100,000 population.

3. Have you had frequent or prolonged visits to one or more of the countries listed above with a high incidence of TB disease? If yes, CHECK the countries above. ☐ Yes ☐ No

4. Have you been a resident/employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, or homeless shelters? ☐ Yes ☐ No

5. Have you ever been a member of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low income or abusing drugs or alcohol? ☐ Yes ☐ No

Notification of Student Health Services Policies

PRIVACY AND CONFIDENTIALITY
With a student's consent, Student Health Services may disclose information for the purposes of providing medical treatment and bill the student's insurance company for services and treatment received. In some circumstances Student Health Services providers may need to disclose health information without a student's written consent:

- If necessary to protect the health and safety of the student or others;
- As a result of a court order or subpoena;
- To verify to the university whether the student has completed all mandatory immunizations;
- Other instances required by law; for example, certain communicable diseases must be reported to the Benton County Health Department.

For more detail regarding confidentiality notification please consult: http://studenthealth.oregonstate.edu/general/policies-and-guidelines/privacy-and-confidentiality.

IMMUNIZATION REQUIREMENTS
OSU policies, Oregon State law (ORS 433.282 and 433.284) and the corresponding Administrative Rules (333-050-0130) require a completed series of Measles, Mumps, and Rubella (MMR) vaccinations. Along with the MMR vaccination, OSU polices also require Quadrivalent Meningococcal (MCV4), Meningococcal B, Hepatitis B, Tdap, and Varicella. For complete immunization information please refer to http://studenthealth.oregonstate.edu/general/policies-and-guidelines/immunizations-tb-screening-and-health-history. Immunization records and a completed health history form must be submitted to OSU Student Health Services within the first six weeks of your first term. **If this form and dates of immunization are not submitted within 6 weeks of your first date of attendance at OSU, a registration hold will be placed on your university account.** We strongly advise that students obtain all required immunizations prior to arrival on campus.

RIGHTS AND RESPONSIBILITIES
Patients have the right to impartial access to treatment or accommodations that are available or medically necessary. Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to their health. For more detail regarding rights and responsibilities, please see: http://studenthealth.oregonstate.edu/general/policies-and-guidelines/rights-and-responsibilities.

CHARGES
There are charges for a number of services at Student Health Services, such as lab tests, x-rays, and immunizations.

BILLING PRACTICES
Students presenting to SHS should bring their current insurance card and picture ID.

- For student sponsored Aetna and Pacific Source Plans: We are 'in network' and will directly bill the insurance company. Your student account will only be billed for what is not covered by insurance.
- For all other insurance plans: We bill any 'out of network' plan as a courtesy. The charges will first be applied to your student account. The insurance company may pay you directly, or if the company pays SHS directly we will subtract that amount from your student account.
- For OSU Student Employee Worker's Comp and Motor Vehicle Accidents: We will directly bill and accept payment in full from the covering insurance agency.

OREGON HEALTH PLAN
OSU Student Health Services is not a primary care provider for the Oregon Health Plan (OHP). OHP patients will be held financially responsible for any and all charges incurred at Student Health Services when they are not covered by OHP. You must notify Student Health Services immediately if you have applied for the Oregon Health Plan and are attempting to receive services at Student Health Services.

MEDICARE: OSU Student Health Services is not a service provider for Medicare patients.

PHOTO IDENTIFICATION: Your university photos will be incorporated into the SHS medical record for internal identification and safety purposes.

I have read and understand the above notifications.
To the best of my knowledge, the health and immunization history I have given is accurate. I understand that if this form is not completed within 6 weeks after my first date of attendance at OSU, a registration hold will be placed on my university account.

_____

Student Signature Printed Name

Student ID # _____ Date _____

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