

REPORT OF MEDICAL HISTORY

CENTENARY COLLEGE OF LOUISIANA

To the Student: YOU HAVE BEEN ACCEPTED. Information you provide will not be used to influence your situation at the College; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent. **PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION.**

Name (print)

Last First Middle/Complete Social Security No.

Home Address _____
City State Zip Telephone No.

Date of Birth _____ Male Female Marital Status _____

Class you are entering: Freshman Sophomore Junior Senior Previously enrolled here? Yes No

Proposed Date of Registration: Fall Spring Summer 20____

Emergency Contact: _____
Name Relationship

Address Telephone Number

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

	Age	State of Health	Occupation	Age/Cause of Death	Yes	No	Relationship
Father							
Mother							
Brothers							
Sisters							

	Yes	No	Relationship
Diabetes			
Heart Disease, Stroke			
Cancer			
Asthma, Allergies			
Tuberculosis			
Alcohol/drug problem			
Depression			

PERSONAL HISTORY Please answer all questions.

Have you had:	Yes	No	Have you had:	Yes	No
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
German Measles	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	throat trouble	<input type="checkbox"/>	<input type="checkbox"/>
Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
More than 10 lb	<input type="checkbox"/>	<input type="checkbox"/>	Food/drug allergy	<input type="checkbox"/>	<input type="checkbox"/>
weight gain or			Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
loss in past year			Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Females:			Severe allergies	<input type="checkbox"/>	<input type="checkbox"/>
menstrual	<input type="checkbox"/>	<input type="checkbox"/>	requiring Epipen		
problems			Please list all allergies:		

Please comment on all positive answers.

Have you had:	Yes	No	Have you had:	Yes	No
Head injury or	<input type="checkbox"/>	<input type="checkbox"/>	Disease or injury	<input type="checkbox"/>	<input type="checkbox"/>
concussion	<input type="checkbox"/>	<input type="checkbox"/>	of joints		
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Back problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety or	<input type="checkbox"/>	<input type="checkbox"/>	Stomach or	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>	intestinal problem	<input type="checkbox"/>	<input type="checkbox"/>
Sleep difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Liver or Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	problem	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol/drug	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, cancer	<input type="checkbox"/>	<input type="checkbox"/>
problem	<input type="checkbox"/>	<input type="checkbox"/>	or cyst	<input type="checkbox"/>	<input type="checkbox"/>
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes or use smokeless tobacco?		
Do you take any medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Give details)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Give details) Have you been hospitalized or received in-patient care for any of the above-mentioned conditions?		
Have you had any significant illness or injury for which you have been treated or hospitalized other than already noted? (Give details)		
Do you have any question in regard to your health, family history, or other matters?		

Student's Signature _____

Physician's Signature (Acknowledging Review) _____

Date _____



OFFICE OF HEALTH SERVICES
 CENTENARY COLLEGE OF LOUISIANA

PHONE (318) 869-5671
 2911 CENTENARY BOULEVARD

FAX (318) 841-7235
 SHREVEPORT, LA 71104

PHYSICAL EXAMINATION

CENTENARY COLLEGE OF LOUISIANA

To the Examining Physician:

Please review the student's history and complete the physical examination and immunization record. Please comment on all positive answers.

Last Name _____ First Name _____ Middle _____ Sex Male Female
 Blood Pressure _____ Pulse _____ Height _____ inches Weight _____ lbs.
 Vision: Right 20/ _____ Left 20/ _____ Corrected Uncorrected
 Dip urinalysis _____ HCT or HGB _____ or not indicated _____

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

Please comment on all positive answers.

	Yes	No	Comment		Yes	No	Comment
Head, Ears, Nose, or Throat	<input type="checkbox"/>	<input type="checkbox"/>		Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>		Metabolic/Endocrine	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>		Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>		Skin	<input type="checkbox"/>	<input type="checkbox"/>	

Is the patient now under treatment for any medical or emotional condition? Yes No

Is the patient currently taking any medication on a regular basis? Yes No

If yes, list medications: _____

Is there a loss or seriously impaired function of any organ? Yes No

Recommendations for physical activity (PE, intramurals, NCAA Athletics): Unlimited Limited

Explain: _____

Do you have any further recommendations for the care of this student? Yes No

Explain: _____

HEALTH CARE PROVIDER _____

Address _____

_____ Phone _____

Signature _____ Date _____



IMMUNIZATIONS

CENTENARY COLLEGE OF LOUISIANA

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. (All information must be in English.)

See back for information.

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required)

1. Dose 1 given at age 12-15 months or later#1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose#2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

B. TETANUS-DIPHTHERIA (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement. Refer to ACIP for details.)

1. Primary series of four doses with DTaP or DTP: #1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #3 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #4 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$
2. Tetanus-Diphtheria (Td) booster within the last ten years $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

C. POLIO (Primary series in childhood meets requirement, three primary series schedules are acceptable. Refer to ACIP for details.)

1. OPV alone (oral Sabin three doses) #1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #3 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$
2. IPV alone (injected Salk four doses): #1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #3 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #4 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$
3. IPV/OPV sequential #1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #3 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ #4 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

D. TUBERCULOSIS SCREENING required (new guidelines)

1. Does the student have signs or symptoms of active tuberculosis disease? Yes No
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions? Yes No.
If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative (PPD), tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test: Date Given: $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{D}} / \frac{\quad}{\text{Yr}}$ Date Read: $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{D}} / \frac{\quad}{\text{Yr}}$
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 if tuberculin skin test is positive) result: Normal Abnormal
Date of chest x-ray: $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{D}} / \frac{\quad}{\text{Yr}}$

E. HEPATITIS B RECOMMENDED VACCINATION

(Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization a. Dose #1 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ b. Dose #2 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ c. Dose #3 $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

F. MENINGOCOCCAL TETRAVALENT (A, C, Y, W-135) (one dose **required** for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperdemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.

Tetavalent conjugate (preferred; date for revaccination pending): Date: $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

Tetavalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues): Date: $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$ $\frac{\quad}{\text{Mo}} / \frac{\quad}{\text{Yr}}$

HEALTH CARE PROVIDER

Name (please print) _____ Address _____

Signature _____ Date _____

PREMATRICULATION IMMUNIZATIONS FOR CENTENARY COLLEGE OF LOUISIANA

CENTENARY COLLEGE OF LOUISIANA

The Vaccine-Preventable Diseases Task Force of the American College Health Association recognizes that many colleges and universities are mandated by state law to require certain vaccinations for matriculating students. States and educational institutions may require some vaccines, while some may recommend certain vaccinations. This guideline has been reviewed and modified by Health Services at Centenary College of Louisiana consistent with these suggestions, however, Centenary College is requiring a meningococcal vaccination for incoming students.

Vaccine	Age Indicated	Major Indications*	Major Precautions*
Measles, Mumps, Rubella (MMR)	1st dose at age 12-15 months or later; 2nd dose at age 4-6 years or later.	All entering college students born after 1956.	Pregnancy; history of hypersensitivity or anaphylactic reaction to eggs. Neomycin or any component of the vaccine. Guidelines exist for vaccination of persons with altered immunocompetence. (1, 2)
Tetanus, Diphtheria, Pertussis – <i>Diphtheria, tetanus toxoid and acellular (whole-cell) pertussis: DTaP (DTP)</i> – <i>Diphtheria and tetanus toxoid (Td)</i>	Primary series in childhood with DTaP or DTP; booster at age 11-12 years with Td, then every 10 years.	All college students.	History of hypersensitivity to any of the components of the vaccine.
Polio Vaccine – <i>Inactivated (IPV)</i> – <i>Oral poliovirus (OPV)</i>	Primary series in childhood with IPV alone, OPV alone, or IPV/OPV sequentially; booster only if needed for travel after age 18 years.	IPV for certain international travelers	History of hypersensitivity to any of the components of the vaccine. OPV should not be given to immunocompromised or HIV antibody positive persons.
Varicella	Childhood, adolescence. Young adulthood. If 13 years of age or older, two doses at least one month apart.	All entering college students without a history of disease or without appropriate immunization or with a negative antibody titer	Pregnancy, history of hypersensitivity or anaphylaxis to any of the components of the vaccine. Guidelines exist for the vaccination of persons with altered immunocompetence. (1, 2)
Recommendation for vaccination Hepatitis B Vaccine	Series of 3 doses given at 0, 1-2 mos., and 6-12 mos. Prior to college entry.	All college students	History of hypersensitivity to any of the components of the vaccine.
Meningococcal Tetravalent (A, C, Y, W-135) – Conjugate (Preferred) – Polysaccharide (Acceptable alternative if conjugate not available)	11-55 years (data for revaccination pending). Over 2 years of age, repeat every 3-5 years if increased risk continues	Populations at increased risk, including freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Non-freshmen college students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.	History of hypersensitivity to any of the components of the vaccine.

*1 CDC. Recommendations of the Advisory Committee on Immunization Practices (ACIP): use of vaccines and immune globulins in persons with altered immunocompetence.

MMWR 1993; 42 (RR-4): 1-18

*2 CDC. General recommendations on Immunization: recommendations of the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Family Physicians (AAFP).

MMWR 2002;51 (RR-2): 1-35

*Refer to the appropriate Advisory Committee on Immunization Practices (ACIP) recommendations for more details.