HARRIS-STOWE STATE UNIVERSITY

Division of Student Affairs

Office of Student Health Services

Greetings!

We are excited to welcome you to the family of Harris-Stowe State University. Below you will find the list of required documents, with explanation, that are necessary for either general admission or admission with residential housing. Documentation can be submitted in any of the following three ways –

1.) BY MAIL:
Harris- Stowe State University
Office of Student Health Services
3025 Laclede Ave St. Louis, MO 63103

2.) BY FAX: (314) 340-5181

3.) BY EMAIL: healthservices@hssu.edu

If you have any questions or need any additional information, please feel free to call the Office of Student Health Services at (314) 340-5052 or 5053. Thank you and welcome to Harris-Stowe.

General Admission Requirements

All students seeking admission to Harris-Stowe State University for full-time undergraduate studies must provide the following documentation to the Office of Student Health Services prior to being confirmed for class registration.

Physical Examination Part A: completed and signed by the student or the parent or guardian if student is under18 years of age.

Authorization for Release of Health Information: this HIPAA Compliant authorization is valid for one year, for the purpose of health assessment and planning for health care services.

Immunizations: documentation of up-to-date immunization status, including month, day and year of each immunization completed by the health care provider and signed by a physician.

Health Insurance: proof of health insurance with supporting documentation:
1) A copy (front & back) of your insurance card, with student's name listed
2) A letter of coverage verification (noting the student's name and policy/member number) from the insurer.

Consent to Treat: this form must be signed by the parent(s) or guardian(s) of students under 18 years of age.

Residential Housing Requirements

All students seeking admission to reside on the campus of Harris-Stowe State University in either the Freeman R. Bosley or William Gillespie Residential Halls must provide the following documentation to the Office of Student Health Services prior to receiving confirmation of their housing assignment.

Physical Examination Part A and B: Physical Examination Form, including health history and medical examination, dated within the last year that is completed and signed by a physician (M.D./D.O./A.R.N.P./P.A./Chiropractor).

Authorization for Release of Health Information: this HIPAA-Compliant authorization is valid for one year, for the purpose of health assessment and planning for health care services.

Immunizations: documentation of up-to-date immunization status, including month, day and year of each immunization completed by the health care provider and signed by a physician, which must include the following:

- 2 doses of Measles vaccines - documentation of vaccine separated by at least one month on or after the first birthday or documentation of physician-diagnosed disease or laboratory evidence of immunity
- 3 doses of Hepatitis B vaccines - strongly recommended for all students
- 2 doses of Varicella - documentation separated by at least one month or documentation of physician-diagnosed disease or laboratory evidence of immunity or birth in U.S. before 1980
- 1 Tetanus/Diphtheria - documentation of primary series of diphtheria and tetanus toxoid and a booster within the past 10 years
- Meningococcal vaccine(s) - required for all students living in residence halls
- Tuberculin test - screening is required for all students. Tuberculosis testing is mandated for:
  - International students born in a country with a high incidence of tuberculosis
  - Students with a history of living or traveling for more than two (2) months in areas with a high incidence of tuberculosis disease
  - Students with signs or symptoms of active tuberculosis, a positive tuberculosis skin test or close contacts with a person known to have active tuberculosis
  - Students who have worked in nursing homes, hospitals or other residential institutions

  A current (within the past year) negative Tuberculosis (TB) test (PPD). If the results are positive, then confirmation of a negative chest X-ray is required. If the student has had a past positive TB test (PPD) and is no longer required to take a TB test, then a TB Risk Assessment will need to be completed and submitted to the office of Student Health Services prior to receiving confirmation of their housing assignment.

Health Insurance: proof of health insurance with supporting documentation: a copy (front & back) of your insurance card, with student's name listed.

Consent to Treat: this form must be signed by the parent(s) or guardian(s) of students under 18 years of age.

Revised 6-1-2016

HARRIS-STOWE STATE UNIVERSITY **Medical Examination Form –Part A**

Student ID#_____

Student_____ **Birthdate** ____/____/____
Last **First** **Middle**

Sex: ____**F**_____**M Age**_____ **Home Phone**_____ **Student Cell Phone #**_____

Address _____
Street **City** **State** **Zip**

Instructions: All questions must be answered. Any further health problems must be discussed with your personal physician or physician administering this exam. This screening physical examination is a confidential document.

	Medical History: Please explain YES answers in detail.	**YES**	**NO**	**Please explain YES answers below.**
1.	Have you had a medical illness or injury since your last athletic or regular check-up?			
2.	Do you have an ongoing or chronic illness?			
3.	Have you ever had surgery or been advised to have surgery?			
4.	Are you currently taking any prescription or nonprescription (over-the-counter) medications, pills, or inhaler?			
5.	Have you ever taken any supplements or vitamins to help you gain or lose weight or to improve your performance (i.e. Creatine, Multivitamins)?			
6.	Do you have any allergies (i.e. pollen, medicine, food, or stinging insects)?			
7.	Have you ever had any skin problems (i.e. rash, hives, ringworm, MRSA)?			
8.	Have you ever passed out during exercise?			
9.	Have you ever been dizzy during or after exercise?			
10.	Have you ever had chest pain during or after exercise?			
11.	Have you ever had racing of your heart or skipped heartbeats?			
12.	Have you had high blood pressure or high cholesterol?			
13.	Have you ever been told that you have a heart murmur?			
14.	Has any family member or relative died of heart problems or of sudden death before the age of 50?			
15.	Have you ever had a severe viral infection (i.e. myocarditis or mononucleosis) within the past six months?			
16.	Has a physician ever denied or restricted your participation in sports for any reason?			
17.	Have you ever had a head injury or concussion?			
18.	Have you ever been knocked out, become unconscious, or suffered memory loss?			
19.	Have you ever had a seizure?			
20.	Do you have frequent or severe headaches?			
21.	Have you ever had numbness or tingling in your arms, hands, legs, or feet?			
22.	Have you ever had a stinger, burner, or pinched nerve?			
23.	Have you ever become ill from exercising in the heat?			
24.	Do you cough, wheeze, or have trouble breathing during or after activity?			
25.	Do you have asthma?			
26.	Do you have seasonal allergies?			
27.	Have you ever had ear problems?			
28.	Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position (i.e. knee brace, orthotics, retainer, hearing aid)?			
29.	Have you ever had any problems with your eyes or vision?			
30.	Do you wear glasses, contacts, or protective eyewear?			
31.	Have you ever broken or fractured any bones or dislocated any joints?			
32.	Have you had any problems with pain or swelling in muscles, tendons, bones, or joints? If you answered yes to questions 30-31, circle the appropriate areas and explain below:			
33.	Do you smoke or use smokeless tobacco?			
34.	Have you ever used illegal substances such as marijuana, cocaine, LSD, ecstasy or other illegal substances?			
35.	Do you lose weight regularly to meet weight requirements for your sport?			

Medical History: Please explain YES answers in detail.

	YES		YES		YES		YES
Asthma		Dizziness/ Fainting		Gall Bladder Disorder		Mood Swings	
Back Problems		Ear Problems		Encephalitis		Muscle Bone Problems	
Blood Disorders		….Do you require signing?		Gum Disease		Nasal Problems	
Blood Pressure High		Epilepsy		German Measles		Migraine	
Blood Pressure Low		Eye disorder, Infection		Hay Fever		Mumps	
Chest Pain/Pressure		Eating Disorder		Headache (Recurrent)		Palpitations	
Chronic Cough		Arthritis		Heart Disease		Pneumonia	
Dental Disorder		Anemia		Hepatitis		Rheumatic Fevers	
Depression		Appendicitis		HIV Infection		Rupture Hernia	
Diabetes		Bloody Urine		Jaundice		Scarlet Fever	
Dysmenorrhea Cramps		Chickenpox		Kidney Disorder		Sexually Transmitted Disease	
Irregular/excessive Flow		Chronic Cough		Malaria		Substance Abuse	
Anxiety		Seizures		Mental Illness		Sleep Disturbance	
Alcohol Abuse		Diabetes		Mononucleosis		Stomach Disorder	
Surgery		Throat Problems		Tumor/Cancer/Cyst		Weakness/Paralysis	
Tuberculosis		Whooping Cough		Sickle Cell Trait		Other Disorders: List Below	

Please explain YES answers in detail below.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Student_____**Date**_____

Part B

Physicians Examination: Please check abnormal findings and explain below after thoroughly evaluating the personal medical history on this form.

Height_____ Weight_____ Blood Pressure_____ Pulse Rate_____ Vision: R20/_____L20/_____

Corrected Lenses Yes☐ No☐ Urinalysis: Protein_____ Sugar_____ pH_____

	Normal	Abnormal	Describe Abnormality in Detail.
Eyes			
Head, Ears, Nose, Throat			
Respiratory			
Cardiovascular			
Abdomen			
Musculoskeletal			
Neurological			
Spine			
Skin			
Genitalia and anus			
Breasts			
Reflexes			

Mental Health Care Required: If so, specify: _____

I have on this date personally examined this student, reviewed the history and other data recorded on both sides of this form, and find this student physically able to compete in intercollegiate athletics without any restrictions.

☐ Full Participation ☐ Limited Participation ☐No Participation Comments: _____

Physician's Name (printed) _____ Telephone: _____

Physician's Signature_____MD, DO, ARNP, PA Date: _____

Harris- Stowe State University

MENINGOCOCCAL VACCINATION REQUIREMENT

As mandated by section 174.335.1, RSMo, beginning with the 2004-05 school year and for each school year thereafter, every public institution of higher education in Missouri shall require all students who reside in on-campus housing to have received the meningococcal vaccine unless a signed statement of medical or religious exemption is on file with the institution's administration. A student shall be exempted from the immunization requirement of this section upon signed certification by a physician licensed under chapter 334 indicating that either the immunization would seriously endanger the student's health or life or the student has documentation of the disease or laboratory evidence of immunity to the disease. A student shall be exempted from the immunization requirement of this section if he or she objects in writing to the institution's administration that immunization violates his or her religious beliefs.

Student Information:

Complete this portion and Section 1 or Section 2 below (not both).

Return completed to the Office of Health Services Rev 3-10-15

Student Name: _____ Date of Birth: _____

Student Id: _____ Social Security Number: _____

Section 1: Students who have received the vaccine

I have received the meningococcal vaccine, or have documentation of the disease or laboratory evidence of immunity to the disease. A copy of the required documentation of vaccination, disease or laboratory evidence is attached.

Printed name of student: _____

Signature of student: _____ Date: _____

Section 2: Waivers - Students who have NOT received the vaccine (complete part A or B)

A. Medical Waiver:

The above named student is exempt from receiving the meningococcal vaccine because the physical condition of the student would endanger their life or health or is medically contraindicated due to other medical conditions.

Physician/Physician's Designee Name (Print or Type): _____

Physician/Physician's Designee Signature: _____ Date: _____

B. Religious Waiver:

I hereby decline the vaccination for meningococcal for reasons of my/our religious belief.

Printed name of student: _____

Signature of student: _____ Date: _____

Signature of Parent/Legal Guardian (Required if student is under 18 years of age):

_____ Date: _____

HARRIS-STOWE STATE UNIVERSITY

TUBERCULOSIS SCREENING QUESTIONNAIRE

_____
STUDENT NAME

STUDENT ID#: _____

_____
DATE OF BIRTH

Please answer the following questions:

Yes	No	Have you lived or traveled for >2 months in Asia, Africa, Central or South America or Eastern Europe?
Yes	No	Were you born on one of these continents?
Yes	No	Have you ever been vaccinated with BCG?
Yes	No	Have you ever had a positive TB skin test or history of active tuberculosis infection?
Yes	No	Has anyone living in your household ever had a history of active tuberculosis?
Yes	No	Have you worked or volunteered in a nursing home, hospital, homeless shelter, prison or other health care facility?

If the answer is **NO** to all of the above questions, no further testing or action is required. Please sign below and forward this form with your immunization record to Harris-Stowe Student Health Services A physician's signature is not required on this questionnaire if you answered NO to all the questions.

If the answer is **YES** to any of the above questions, then Harris-Stowe State University requires that a health care provider complete a tuberculosis risk assessment within 6 months prior to the start of class. Results of a tuberculin skin test (PPD) or IGRA blood test such as Quantiferon gold or a T-spot must be provided, unless a previous positive test has been documented. A chest x-ray performed within six months prior to the first day of class is required for a positive PPD or IGRA. A written medical interpretation of the x-ray (in English) must be included.

NOTE: Testing is recommended (but not mandated) for individuals in the following groups:

- HIV positive
- Immunosuppressive disorders from illness or medication (e.g. organ transplants, prednisone)
- History of IV drug abuse or alcoholism
- Students with chronic medical conditions (e.g. diabetes, cancer, kidney disease, malabsorption disorders, etc)

TB (Tuberculin) Skin Test - Date Administered: _____

-OR- equivalent blood test result: _____

Chest X-ray required if TB test is positive: Date: _____

Result: NORMAL ABNORMAL

(Attach written medical interpretation of Chest X-ray in English).

Dates of treatment: _____

Physician/ Clinic name: _____

Physician/ Clinic address: _____

_____

_____

Phone number: _____

Physician signature: _____ Date: _____

(Physician signature is only required if providing TB test results, blood test results or chest x-ray).

By signing I attest that the above information is true to the best of my knowledge

Student signature: _____Date: _____

HARRIS - STOWE STATE UNIVERSITY

Office of Student Health Services

Consent to Treat

Students under the age of 18 years old

STUDENT NAME_____ DATE OF BIRTH_____

I,_____ give consent for _____,
PARENT/GUARDIAN STUDENT

To receive medical services from the health care professional assigned to Student Health Services, local hospitals and/or other licensed medical facilities for illness or injury.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

Contact information:

(_____)_____ (_____)_____
HOME MOBILE

_____
E-MAIL

HARRIS-STOWE STATE UNIVERSITY
DIVISION OF STUDENT AFFARIS, OFFICE OF HEALTH SERVICES

HIPAA-Compliant Authorization for Release of Health Information

Student Name _____ Date of Birth _____

I hereby authorize _____

Primary Care Provider, Address, and Phone

To release my or my child's health information/records for the purposes listed below to:

HSSU Student Health Services
3025 Laclede Ave
St. Louis, MO 63103
314-340-5052 office 314-340-5181 fax

Description:

The information to be disclosed consists of:

_____

_____

_____

Purpose:

This information will be used for the following purpose(s):

- ❑ Educational evaluation and program planning.
- ❑ Health assessment and planning for health care services and treatment in school
- ❑ Medical evaluation and treatment.
- ❑ **Other _____**

Authorization

This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____
Student Signature Date

_____ _____
Parent Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Missouri, a competent minor, depending on age, can consent to alcohol and drug abuse treatment, testing for STD-HIV/AIDS, reproductive health care services, and general medical care.