2019 - 2020
FRANKLIN COLLEGE STUDENT HEALTH RECORD

1. A **complete, accurate and legible** Student Health Record is required for **all** students. It is expected that all requested information will be provided honestly and completely.
2. Future *Registration Stops* will be placed on those failing to complete and submit the Health Record.
3. Students will not be placed in clinical experience without a complete Health Record.
4. The provided information is strictly for the use of Health Services and the MSAT program. By submitting this form you are consenting to share relevant information regarding immunizations for MSAT accreditation purposes. Further information will not be released to anyone without the student's knowledge and written consent. Indiana state law prohibits disclosure of patient information without patient's signed consent, if over age 18.
5. Please **submit electronically, mail or deliver Health Record directly to** Jennifer Austin, MSAT Program Director, jaustin@franklincollege.edu; **101 Branigin Blvd., Franklin, IN 46131-2623.**

GENERAL INFORMATION

Date this form completed: _____ Intended Graduation Year: _____

Student Legal Name: _____
Last First Middle

Date of Birth: _____ Male □ Female □ Email: _____

Permanent Address: _____
Street

_____
City State Zip

Home Telephone: (___) _____ Student Cell Number: (___) _____

Father's Name: _____
Home Telephone: (____)_____ Cell Telephone: (_____)_____
Mother's Name: _____
Home Telephone: (_____)_____ Cell Telephone: (_____)_____

If you do not live with a parent please indicate the name of your Guardian or Spouse:
Name: _____ Relationship: _____
Home Telephone: (____)_____ Work Telephone: (____)_____

INSURANCE INFORMATION

Please check with your insurance carrier to confirm coverage is extended to you as a student over the age of 18 years old. Franklin College expects all students to have some form of health insurance. It is the responsibility of each student to secure personal health insurance.
Name of Insurer: _____ Policy Number _____
Insurance Holder _____ Date of Birth of Insurance Holder ___/___/___

- **Please attach a copy of both sides of any insurance or prescription cards and write birth dates of responsible party and the student on the copy.**

Last Name: _____ First Name: _____ DOB: _____

IMMUNIZATIONS

Indiana State Law (IC21-40-5) requires that post-secondary students provide proof of vaccination against measles, mumps, rubella, tetanus, diphtheria and meningitis. Indiana State law also requires that individuals be provided information, and indicate receipt by signatures, on the risks associated with meningococcal disease and the availability and effectiveness of vaccinations. Specific majors, classes, and activities may have additional health requirements. Request for exemptions based on medical or religious reasons must be filed with Student Health Services.

REQUIRED FOR ALL FRANKLIN STUDENTS **Please provide month/day/year of vaccination**

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ..... #1 ____/____/_____
2. Dose 2 given at least 28 days after first dose . ..... #2 ____/____/_____

B. POLIO

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
2. IPV/OPV sequential: IPV #1 ____/____/_____ IPV #2 ____/____/_____ OPV #3 ____/____/_____ OPV #4 ____/____/_____
3. IPV alone (injected Salk four doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____

C. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____
2. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____

D. VARICELLA

1. Immunization
   a. Dose #1 ..... #1 ____/____/_____
   b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. ..... #2 ____/____/_____
2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

E. HEPATITIS B

1. Immunization (Hepatitis B)
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

F. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV3) _____ Live attenuated influenza vaccine (LAIV) _____

Date of last dose: ____/____/_____

Last Name: _____ First Name: _____ DOB: _____

G. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/_____

I have read and reviewed information below on the risks associated with meningococcal disease, availability, and effectiveness of the meningococcal vaccine. I choose NOT to be vaccinated against meningococcal disease.

_____ _____

Signature of student (18 years or older) Date

H. TUBERCULOSIS (TB)

Date read: ____/____/_____ Time: _____ Site: _____

Result: _____ Positive _____ Negative

HIGHLY RECOMMENDED

A. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

B. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

C. SEROGROUP B MENINGOCOCCAL

1. MenB-RC (Bexsero) __ routine ____outbreak –related

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

   OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related

   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

Last Name: _____ First Name: _____ DOB: _____

PERSONAL HEALTH INFORMATION

Check all applicable conditions. Describe details below.

Allergies (Medicine, Food, Environmental, etc.) Please list

_____
_____
_____
_____

- ☐ ADHD
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding Tendency
- ☐ Bulimia
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Disordered Eating
- ☐ Head Injury
- ☐ Heart disease/Abnormality
- ☐ Heart Murmur
- ☐ Hepatitis A, B, C
- ☐ Hospitalization
- ☐ Immune Disorders
- ☐ Infectious Mono, year _____
- ☐ Irritable Bowel
- ☐ Menstrual Cramps
- ☐ Migraine Headaches
- ☐ Kidney Problems
- ☐ Ovarian Cysts
- ☐ Rheumatic Fever
- ☐ Seasonal Allergies
- ☐ Seizure Disorder/Conditions
- ☐ Smokes Cigarettes
- ☐ Surgeries - Describe Below
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Tumor - Note Below
- ☐ Ulcer
- ☐ Urinary Tract Infections
- ☐ Other
- ☐ Do you regularly take/use:

Allergy Injections

_____

Prescription drugs - Please list:

_____
_____
_____
_____

*Height: _____
*Weight:_____

Notes:_____
_____
_____
_____

Please detail any of the above positive responses, including diagnosis, age, duration, treatment, and outcome. If you have any serious, chronic medical problems, any additional information you can provide would be greatly appreciated and helpful. Feel free to attach additional sheets as needed.

Health care provider: please sign verifying accuracy of immunizations and health information.

Name of Clinic or Physician office _____

Printed name of Health Care Provider _____

_____ _____

Signature of Health Care Provider **Date**

All communication and records related to care received is confidential and will be released to individuals outside of the MSAT Program and Health Service only with the signed consent to do so except as required by state law in situations when limited disclosure is necessary to protect life or to protect the community. Situations specified by Indiana Stare Law are: child abuse, abuse of the elderly, immediate risk if harm to self or others, the reporting of communicable diseases to the Health Department, and data subpoenaed by a court of law.

I hereby grant permission to the medical staff of Franklin College Health Service to examine and/or provide treatment for minor injuries and illness and when considered necessary to make referral to an appropriate facility. I also consent to emergency treatment or procedures by a licensed care professional as deemed necessary. I acknowledge that no representation or guarantees as to the results or cure will be made.

_____ _____

Signature of Student **Date**

Last Name: _____ First Name: _____ DOB: _____

MENINGOCOCCAL DISEASE AND MENINGOCICCAL VACCINATION

Effective October 1, 2002, Indiana passed a law requiring postsecondary institutions to provide detailed information on the risks associated with meningococcal disease and the availability and effectiveness of vaccination to students and parent or guardian, if the individual is less than eighteen (18) years of age. Students choosing not to receive the vaccine must sign a waiver indicating they are aware of disease implications and are knowingly declining vaccination.

Meningitis is an inflammation of the membranes that cover the brain and spinal cord. People sometimes refer to it as spinal meningitis. Meningitis is usually caused by a viral or bacterial infection. Knowing whether meningitis is caused by a virus or bacterium is important because the severity of illness and the treatment differ depending on the cause. Viral meningitis is generally less severe and clears up without specific treatment. But bacterial meningitis can be quite severe and may result in brain damage, hearing loss, or learning disabilities. For bacterial meningitis, it is also important to know which type of bacteria is causing the meningitis because antibiotics can prevent some types from spreading and infecting other people.

High fever, headache, and stiff neck are common symptoms of meningitis. Symptoms can develop over several hours, or they may take 1 to 2 days. Other symptoms may include nausea, vomiting, discomfort looking into bright lights, confusion, and sleepiness. As the disease progresses, patients of any age may have seizures. Early diagnosis and treatment are very important. Fortunately, none of the bacteria that cause meningitis are as contagious as things like the common cold or the flu. Also, the bacteria are not spread by casual contact or by simply breathing the air where a person with meningitis has been. Sometimes the bacteria that cause meningitis have spread to other people who have had close or prolonged contact with a patient with meningitis caused by Neisseria meningitidis (also called meningococcal meningitis) or Hib. Meningitis vaccines are safe and highly effective.

There are two types of meningococcal vaccines available in the United States:

- ***Conjugate vaccines*** *(Menactra® and Menveo®) (**Conjugate:** A type of vaccine that joins a protein to part of the bacteria to improve the protection the vaccine provides.)* ***Menactra®****: Two doses are given to preteens and teens. It is also given to certain people at increased risk of meningococcal disease. It helps protect against four types of the bacteria that cause meningococcal disease (serogroups A, C, W, and Y).* ***Menveo®****: Two doses are given to preteens and teens. It is also given to certain people at increased risk of meningococcal disease. It helps protect against four types of the bacteria that cause meningococcal disease (serogroups A, C, W, and Y).*

- ***Serogroup B (recombinant) vaccines*** *(Bexsero® and Trumenba®) (**Recombinant:** A type of vaccine where proteins from certain bacteria are used to help the body build protection against that germ.)* ***Bexsero®****[11 pages]: It is given as a two-dose series to people 16 through 23 years old who are not at increased risk of meningococcal disease. It is also given as a two-dose series to people 10 years or older at increased risk of meningococcal disease. It helps protect against one type of the bacteria that causes meningococcal disease (serogroup B).* ***Trumenba®****[11 pages]: It is given as a two-dose series to people 16 through 23 years old who are not at increased risk of meningococcal disease. It is given as a three-dose series to people 10 years or older at increased risk of meningococcal disease. It helps protect against one type of the bacteria that causes meningococcal disease (s*erogroup B).

For more information:

- *Ask your healthcare provider for additional information.*
- *Call your local or state health department.*
- *Contact the Centers for Disease Control and Prevention (CDC) CDC.gov/vaccines or 1-800-232-4636. https://www.cdc.gov/meningococcal/index.html*
- *Franklin College Health Service – 317-738-8090 or cdecleene@franklincollege.edu*