

TEXAS SOUTHERN UNIVERSITY

OFFICE OF REGISTRAR

3100 Cleburne Street , Houston, Texas 77004

(713) 313-7071

STUDENTHEALTH FORM

All freshmen and transfer students planning to attend Texas Southern University are required to submit this complete form prior to registration

PURPOSE OF HEALTH FORM

- To provide information in the event of a medical emergency
- To assist Health Services by providing information that is not immediately obtained from the student
- To indicate conditions for which a student may need care or assistance while at T.S.U.
- To comply with T.S.U. statutes concerning student immunizations
- To establish an ongoing individual health record for each student receiving care at the Student Health Center

INSTRUCTIONS

1. Answer all questions
2. Complete personal history
3. Have a physician complete Physical Examination and sign Immunization Record
4. Transfer students may send copy of health records from previous university/college if they fulfill these requirements

MAIL THIS FORM DIRECTLY TO THE STUDENT HEALTH CENTER BEFORE.....

Student Health Center

3100 Cleburne Street

Houston, Texas 77004

713-313-4284

ABOVE INFORMATION IS REQUIRED TO COMPLETE REGISTRATION

Student Name: _____
Last *First* *Middle*

Social Security Number: _____
/ /

Date of Birth: _____
Month *Day* *Year*

Date: _____
Month *Day* *Year*

Personal and Family History

Information on this page will only be used by the Health Center and is confidential. It will not be released without your permission.

Name: _____
Last *First* *Middle*

Sex: _____ Marital Status: _____ Citizenship: _____

Home Address: _____
Street

Phone: (_____) _____ E-Mail: _____ @ _____
City *State* *Zip*

PARENT OR GUARDIAN:

Name: _____ Relationship: _____
Last *First* *Middle*

Street Address: _____
Street

Home Phone: (_____) _____ Work Phone: (_____) _____
City *State* *Zip*

FAMILY HISTORY:

Father: Living Deceased

Age at Death _____

Cause _____

Mother: Living Deceased

Age at Death _____

Cause _____

Siblings:

Living _____

Deceased _____

Allergies

Cancer

Heart Disease

Seizure Disorder

Arthritis

Asthma

Diabetes

Emotional Illness

Kidney Disease

High Blood Pressure

Tuberculosis

PERSONAL MEDICAL HISTORY

If you will be receiving allergy shots, bring medication with physician's orders to the Health Center.

Do you have a medical disability?

Do you have special needs?

Are you receiving ongoing treatment from a physician?

Are there medications involved? If yes, please list.

Is local physician follow-up needed?

Do you have additional information Health Services should know in order to provide you with better health care?

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____ Relationship: _____
Last *First* *Middle*

Address: _____
Street

Home Phone: (_____) _____ Work Phone: (_____) _____
City *State* *Zip*

Physical Examination

TO THE EXAMINING PHYSICIAN:

Please complete this physician's form. Also note that a signature is required on the immunization form page 4

Student Name: _____
Last *First* *Middle*

Sex: Male Female

Temperature: _____ Pulse: _____ Blood Pressure: _____ / _____

Weight: _____ Weight: _____

DO ABNORMALITIES APPEAR IN THE FOLLOWING SYSTEM?

YES	NO	Explain fully any positive finding
<input type="checkbox"/>	<input type="checkbox"/>	Head, ears, Nose and throat
<input type="checkbox"/>	<input type="checkbox"/>	Respiratory
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular
<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal
<input type="checkbox"/>	<input type="checkbox"/>	Eyes (refractive)
<input type="checkbox"/>	<input type="checkbox"/>	Eyes (other)
<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary
<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	<input type="checkbox"/>	Metabolic/Endocrine
<input type="checkbox"/>	<input type="checkbox"/>	Neuropsychiatric
<input type="checkbox"/>	<input type="checkbox"/>	Skin

If this student is on medication, give name and dosage

Is this student under treatment for any physical or emotional condition? o yes o no

Explain

Any recommendations for care of this student?

Is this student's first visit to your office? o yes o no

Recommendations for physical activity

o Unlimited o Limited o Temporary o Permanent

If limited, explain

Signature of Physician: _____ Date of Examination: _____

Printed name of Physician: _____
Last *First* *Middle*

Address: _____
Street

City *State* *Zip*

Immunization Record

Any religious or medical exemption status must be completed before registration. A letter from your doctor or health department will be accepted in lieu of the signature below.

REQUIRED:

A. Tetanus-Diphtheria

1. Completed primary diphtheria-Pertussis-Tetanus immunization
2. Received Tetanus-Diphtheria booster within last five (5) years

_____/_____
Month Year
_____/_____
Month Year

B. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 - immunized at twelve (12) months of age or after
2. Dose 2 - immunized at five (5) years of age or later

_____/_____
Month Year
_____/_____
Month Year

Must have had second dose before coming to Texas Southern University

C. Polio

Completed primary series of Polio immunization: YES NO

Last booster: _____

D. Tuberculosis (Check appropriate box, PPD *required* regardless of prior BCG inoculation)

- 1. PPD (Mantoux) test within the past year
- 2. Positive PPD - chest x-ray required

Give date and result of chest x-ray _____
Result _____ Month / Day / Year

Not required but recommended: You can always check with your physician, but Texas Southern University and the American College Health Association highly recommend these additional immunization:

E. Hepatitis

Hepatitis B Series

_____/_____/_____
First Second Third

Hepatitis A

_____/_____
First Second

(Especially if planning international travel/study)

F. Varicella (either a history of chicken pox, a positive Varicella antibody, or two doses of a vaccine given at least one month apart if immunized after age 13 years, meet the requirement)

G. Meningococcal (one dose-preferably at entry into college for freshmen living in dormitories or residential halls who wish to reduce their risk of the disease)

REQUIRED:

Health care provider Signature: _____