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 Clecurne 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

_____
City *State* *Zip*

Phone: (_____) _____ E-Mail: _____@_____

PARENT OR GUARDIAN:

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

Street Address: _____
Street

_____
City *State* *Zip*

Home Phone: (_____) _____ Work Phone: (_____) _____

FAMILY HISTORY:

Father: o Living o Deceased
Age at Death _____
Cause _____

Mother: o Living o Deceased
Age at Death _____
Cause _____

Siblings:
Living _____
Deceased _____

o Allergies
o Arthritis
o Kidney Disease
o Cancer
o Asthma
o High Blood Pressure
o Heart Disease
o Diabetes
o Tuberculosis
o Seizure Disorder
o Emotional Illness

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

_____
City *State* *Zip*

Home Phone: (_____) _____ Work Phone: (_____) _____

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**
❑	❑	Head, ears, Nose and throat	
❑	❑	Respiratory	
❑	❑	Cardiovascular	
❑	❑	Gastrointestinal	
❑	❑	Eyes (refractive)	
❑	❑	Eyes (other)	
❑	❑	Genitourinary	
❑	❑	Musculoskeletal	
❑	❑	Metabolic/Endocrine	
❑	❑	Neuropsychiatric	
❑	❑	Skin	

If this student is on medication, give name and dosage

Is this student under treatment for any physical or emotional condition? o yeas 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 diptheria-Pertussis-Tetanus immunization _____/_____ (Month / Year)
2. Received Tetanus-Diphtheria booster within last five (5) years _____/_____ (Month / Year)

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

1. Dose 1 - immunized at twelve (12) months of age or after _____/_____ (Month / Year)
2. Dose 2 - immunized at five (5) years of age or later _____/_____ (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 al 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: _____