



### STUDENT HEALTH RECORD

PLEASE MAIL OR DELIVER DIRECTLY TO STUDENT AFFAIRS PRIOR TO AUGUST 1<sup>ST</sup>

101 Branigin Blvd.

Franklin, Indiana 46131-2623

#### INSTRUCTIONS:

1. **This form is mandatory for all full-time residential students. It must be received prior to August 1<sup>st</sup> for students beginning the fall semester and prior to Feb. 5<sup>th</sup> for those beginning spring semester.**
2. **If this form is not completed and submitted to Student Affairs, a hold will be placed on the student's registration for the following semester. The student will not be able to register for classes.**
3. All information must be in English and legible.
4. **Intercollegiate athletes** must provide additional health information required by the athletic department. This information will be available at [www.franklincollege.edu](http://www.franklincollege.edu) under the athletics tab after May 1st.

#### PERSONAL INFORMATION: (PLEASE TYPE OR PRINT)

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Student ID #: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: Male  Female

Home Address: \_\_\_\_\_  
Street City State Zip Code

Student Cell Phone Number: \_\_\_\_\_ Student Campus E-mail Address: \_\_\_\_\_

Name of Parent or Legal Guardian: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Parent Home Phone Number: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_

#### In Case of Emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone (day): \_\_\_\_\_ (Evening) \_\_\_\_\_

#### Personal Physician:

Name: \_\_\_\_\_ Degree: \_\_\_\_\_ Phone : \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip Code

#### \*\*\*MANDATORY FOR ALL STUDENTS\*\*\*\*

Franklin College **requires** all full-time students provide proof of medical insurance each year. We are happy to make available a low-cost student health coverage plan, serviced and underwritten by Markel Insurance Company. You may review a detailed brochure of the plan coverage on-line at [www.collegeinsurance.com](http://www.collegeinsurance.com). Information regarding the cost of the insurance plan will be sent via e-mail to students in April.

**\*\*\*\*ALL STUDENTS MUST EITHER ENROLL IN OR DECLINE (WAIVE) THIS INSURANCE PRIOR TO AUGUST 1<sup>ST</sup> OF EACH YEAR OF FULL-TIME ENROLLMENT!\*\*\*\*\***

**Failure to do so will result in automatic enrollment in the insurance plan and a charge for the insurance!**

**This must be completed online at [www.collegeinsurance.com](http://www.collegeinsurance.com). Follow the instructions at the site to either enroll in or waive the insurance. The insurance website will be available April 30<sup>th</sup>, 2010.**

**\*\*I hereby acknowledge by signing below, that I have read the above information and understand that it is my responsibility to complete the insurance enrollment or waiver *each year of full-time enrollment* and will not hold the college responsible for my failure to do so. (Must be signed)**

Student Signature (if over 18yrs) \_\_\_\_\_ Date: \_\_\_\_\_

Parent Signature (if under 18 yrs) \_\_\_\_\_ Date: \_\_\_\_\_



- **Polio:** *At least three doses recommended.*

#1 \_\_\_\_ / \_\_\_\_ #2 \_\_\_\_ / \_\_\_\_ #3 \_\_\_\_ / \_\_\_\_ #4 \_\_\_\_ / \_\_\_\_ #5 \_\_\_\_ / \_\_\_\_  
M Y M Y M Y M Y M Y

- **Varicella:** *Recommended for those without history of active disease.*

#1 \_\_\_\_ / \_\_\_\_ #2 \_\_\_\_ / \_\_\_\_  
M Y M Y

- **Hepatitis B:** *Highly recommended for all students.*

#1 \_\_\_\_ / \_\_\_\_ #2 \_\_\_\_ / \_\_\_\_ #3 \_\_\_\_ / \_\_\_\_  
M Y M Y M Y

- **Hepatitis A:** *Recommended for travelers.*

#1 \_\_\_\_ / \_\_\_\_ #2 \_\_\_\_ / \_\_\_\_  
M Y M Y

- **Meningococcal/Meningitis:** *Recommended for undergraduates living in dormitories/residence halls.*

Quadrivalent polysaccharide vaccine: \_\_\_\_ / \_\_\_\_  
M Y

### C. Tuberculosis (TB) Screening Questionnaire

1. Have you ever been in close contact with anyone who has TB, or do you currently have symptoms of acute TB infection?

\_\_\_ Yes \_\_\_ No

2. Have you traveled to or were you born in a country\* that has endemic TB, and arrived in the past five years to the U.S.?

\_\_\_ Yes \_\_\_ No

3. Do you have a chronic medical problem that puts you at risk for TB or other high risk factors\*? \_\_\_ Yes \_\_\_ No

\*Please see [www.acha.org/info\\_resources/tb\\_statement.pdf](http://www.acha.org/info_resources/tb_statement.pdf) for endemic countries and high risk groups.

**If you checked yes for any of the above, you need a TB skin test within six months prior to travel to campus. If you have ever had a positive TB test, you will need either a chest x-ray or QuantiFERON TB-Gold Test within six months prior to arrival to campus.**

TB skin test: Date Placed \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date Read \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result \_\_\_\_\_ mm of induration  
M D Y M D Y

**Please attach a chest x-ray report or QuantiFERON TB-Gold test result if TB skin test 10mm or greater.**

- **Other Immunizations:** (Please list)

1. \_\_\_\_\_ Date \_\_\_\_\_  
2. \_\_\_\_\_ Date \_\_\_\_\_  
3. \_\_\_\_\_ Date \_\_\_\_\_

|                                       |
|---------------------------------------|
| Health Care Provider Signature: _____ |
| Date: _____                           |
| Address: _____                        |
| Telephone Number: _____               |
| Print Physician Name: _____           |

**MENINGOCOCCAL VACCINE WAIVER [must be completed if you have not received or do not plan to receive the meningitis vaccine) please read and sign the following.**

The state of Indiana requires all colleges to educate incoming freshman about meningitis. Studies have indicated freshman college students, especially those living in residence halls; have a six-fold increase risk for meningitis. Some state requires all incoming freshman to receive the meningitis vaccine.

Meningitis is rare; however, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. There are 100 – 124 meningitis cases occurring on college campuses yearly, and as many as 15 students will die from the disease. **MENINGOCOCCAL DISEASE IS A PREVENTABLE DISEASE.**

I have read the information above about meningococcal meningitis and understand the risks of the disease; however, I choose not to receive the vaccine. I understand that in the event of an outbreak, unvaccinated student will be at risk for contracting the illness.

Student's Name Printed \_\_\_\_\_ Student Signature (age 18 over) \_\_\_\_\_

Parent /Guardian signature if under age 18 \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTHCARE -- REQUEST AND AUTHORIZATION [must be completed]**

Parent or guardian; Please complete the following for the student who will be UNDER 18 years of age at the beginning of the school semester.

**PARENTS OF STUDENT UNDER 18:** I request and authorize the Franklin College Student Health medical personnel to provide all reasonably necessary medical care, including but not limited to medical transport, lab tests and possible prescriptions or over-the-counter medications advisable for the health of my son / daughter. I acknowledge that no representation or guarantees as to the results or cure will be made.

Parents Signature \_\_\_\_\_ Date \_\_\_\_\_

**STUDENT AGE 18 AND OLDER: APPROVAL AND CONSENT FOR TREATMENT**

I have reviewed all information on this Health Form and believe it to be accurate. I have reviewed the accompanying information about meningitis. I, the undersigned, authorize and consent to treatment; I understand that I may withdraw my consent at any time. Should I be under eighteen years of age, my parent's (or guardian's) signature above indicates approval and consent for medical treatment at the Student Health Center.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

**Franklin College Student Health Record Waiver due to religious reasons**

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By signing this waiver, I understand I **will not be eligible for treatment or services provided by the Franklin College Student Health Center** staff or visiting physicians.

This waiver may be revoked at any time providing I present a current and complete Student Health Record to the Coordinator for Student Health Services.

I, (print full name) \_\_\_\_\_ do not wish to have a Student Health Record on file at the Franklin College Student Health Center; thus I forfeit my eligibility to seek treatment from the Student Health Center.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_