DENISON

Wellness Examination Form

Student Directions (read before printing)

- **Print this document in color**
- **Print 1 sided (NOT 2 sided)**
- **Prior to giving these papers to your medical clinician** *print your legal name and DOB at the top of each page.*
- **REMINDER:** Form due within 30 days of receiving Denison ID#, username and password. This is especially significant if you have a chronic medical or behavioral health condition that will impact your housing.
- **Once this form is completed by a medical professional, upload it to the My Wellness Portal** (upload directions can be found on the home-page of the portal). **DO NOT include this page in the upload.**

ATTENTION: Medical Professional

WELLNESS EXAMINATION FORM (physical form)

1. *Must be completed, in its entirety,* by a licensed Physician, Nurse Practitioner (NP) or Physician's Assistant (PA). *It CANNOT be completed by a family member.*
2. **The physical needs to have taken place on or after November 1, 2019.**
3. IMPORTANT: To be valid page 4 must be signed and dated by the physician, NP, or PA.

TUBERCULOSIS (TB) TESTING

- All international students must have a TB test.
- Domestic students at risk for TB must have a TB test.

IMMUNIZATION RECORD

Provide an official copy of immunization record OR complete the immunization form provided to you within this document. The American College Health Association (ACHA) recommends the following vaccinations to reduce outbreaks: Influenza, MMR, Meningococcal, Tdap and Varicella. **Denison University requests up-to-date MMR (**2 doses of MMR at least 28 days apart after 12 months of age) **and Tdap** (completion of initial series, and 1 dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Td and Tdap).

Per the Ohio Department of Health, please note that Ohio law requires disclosure of vaccination status of the student.

As relevant to continuity of care, please provide additional medical and/or behavioral health records.

*****ONCE YOU HAVE COMPLETED THE FORM, PLEASE RETURN IT TO THE STUDENT.** The student is responsible for uploading it to the My Wellness Portal.

Whisler Center for Student Wellness
100 West College Street
Granville, OH 43023
(740) 587-6200
wellness@denison.edu

DENISON

Legal Name: _____ **DOB:**___/___/___

PHYSICAL DATE :_____ **HOW LONG HAVE YOU KNOWN THIS PATIENT?** _____

ALLERGIES	**NONE**	☐ **Yes, please list** _____
History of Anaphylaxis? (medications, food, insects)	**NONE**	☐ **Yes, please explain** _____ **Hx Hospitalization r/t anaphylaxis? N or Y**
CURRENT MEDICATIONS	**NONE**	☐ **Yes, please list**_____

MEDICAL HISTORY ☐ NONE

Includes current & past history. Please mark all that apply.

☐ **Anemia** Dx:_____	☐ **Ear disease** Dx: _____	☐ **Kidney Disease** Dx: _____
☐ **Asthma intermittent** ☐ **Asthma persistent**	☐ **Eye Disease** Dx: _____	☐ **Latent TB** Treatment date _____ Medication_____Duration: _____
☐ **Auto-immune Disorder** Dx: _____	☐ **GERD**	☐ **Major Trauma** Explain: _____ Date: _____
☐ **Bone/joint disease** Dx:_____	☐ **Hearing loss/impairment** Hearing Aids Y or N	☐ **Meningitis** ☐ Viral ☐ Bacterial Date: _____
☐ **Cancer** Dx:_____ Tx:_____ Remission: Y or N	☐ **Heart Disease** Dx: _____	☐ **Mononucleosis** Date: _____
☐ **Chickenpox**	☐ **Hepatitis** ☐ A ☐ B ☐ C	☐ **Kidney disease** Dx: _____
☐ **Clotting Disorder** Dx: _____	☐ **High Blood Pressure**	☐ **Pneumonia** Date: _____
☐ **Concussion** # concussions_____ Date of Last Concussion: _____	☐ **Intestinal Disease** Dx: _____	☐ **Pregnancy** Date: _____ Termination Hx: Y or N
☐ **Diabetes Type I** Age of dx: _____ ☐ **Diabetes Type II**	☐ **Irregular Menses** LMP: _____ Frequency ____ Hormonal Contraception use: Y or N	☐ **Rheumatic Fever** Date: _____ ☐ **HIV Date of Dx:**_____
☐ **Seizure Disorder** Date of last seizure: _____	☐ **Sexual Assault** Date:_____ Previous related counseling? Y or N	☐ **Sickle Cell Disease** Age of Dx: _____ Date of last crisis: _____
☐ **Thyroid disease** Dx._____	☐ **COVID19 Infection** **Diagnosis Date:** _____ **Positive Test** ☐**No** ☐**Yes, please submit copy of lab report**	

Legal Name: _____ **DOB:**___/___/___

Surgical Hx: **NONE** ☐ **Yes, please list** _____
_____
_____

BEHAVIORAL HEALTH HISTORY ☐ **NONE**
Includes current & past history. Please mark all that apply.

☐ **Attention/Hyperactivity** Dx:_____	☐ **Learning Disability** Dx:_____	☐ **Autism Spectrum** Dx:_____
☐ **Anxiety or Panic Attacks** Dx:_____	☐ **Depressive Episode(s)** Dx:_____	☐ **Manic Episode(s)** Dx:_____
☐ **Obsessions/Compulsions** Dx:_____	☐ **Anorexia or Bulimia** Dx:_____	☐ **Substance Abuse** Dx:_____
☐ **Post-Traumatic Stress** Dx:_____	☐ **Non-Suicidal Self Injury** Date(s):_____	☐ **Suicidal ideations** **Date(s)**_____

Suicide Attempt(s) **No** ☐ **Yes,** Date(s)_____ Means_____

Behavioral Health Hospitalizations: **NONE** **Yes**, please explain _____
_____

1. Is the student currently under the care of a behavioral health specialist? (counselor, psychologist, psychiatrist)	**No**	**Yes** - proceed to question 1a
(a) Will the student continue to see a behavioral health specialist from home while at Denison?	**No**	**Yes**
2. Is the student seeking a referral to Denison's Wellness Center for future behavioral health counseling &/or medication treatment?	**No**	**Yes** **Undetermined**

Ht _____	Wt _____	BMI _____	BP_____	PULSE_____	LMP: _____ ☐ **n/a**

	NORM	ABN	N.E.	Comments
Head				
Eyes				
ENT				
Teeth				
Neck (incl. thyroid)				
Chest & Lungs				

Legal Name: _____ DOB:___/___/___

	NORM	ABN	N.E.	Comments
Heart				
Abdomen				
Genitalia (incl. hernia)				
Pelvic (if indicated)				
Rectal (if indicated)				
Spine				
Extremities & Joints				
Neurologic				
Skin				
Emotional Status				

Are there any limitations to this student's participation in a full program of physical activity including competitive athletics?	**No**	☐ **Yes, please explain**_____ _____ _____

Does the patient have any risk factors for TB? **No** ☐ **Yes/unknown ----> TB testing indicated.**

TUBERCULOSIS SCREENING - *all international students MUST have TB testing.*

*Domestic students who are at risk for Tuberculosis must also have TB testing.

Tuberculin Skin Test (TST)

(TST result must be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ Date Read: ____/____/____
M D Y M D Y

Result: _____ mm of induration **Interpretation: positive____ negative____

Interferon Gamma Release Assay (IGRA) - *required if previous BCG or previous positive TST.*

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Chest x-ray: *(Required if TST or IGRA is positive)*

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____

Legal Name: _____ DOB:___/___/___

Management of Positive TST or IGRA by Health Care Clinician **N/A**

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication.

- ▢ Student agrees to receive treatment (please attach copy of treatment plan).
- ▢ Student declines treatment at this time

*Please attach a copy of records related to initiation of therapy &/or completion of therapy.

IMMUNIZATIONS

REFER TO ATTACHED IMMUNIZATION RECORD

TETANUS/DIPHTHERIA/PERTUSSIS					
DTP/DTaP Series None	**Mo./day/year**	**Mo./day/year**	**Mo./day/year**	**Mo./day/year**	**Mo./day/year**
Tdap booster *must have one documented	**Mo./day/year**				
MEASLES/MUMPS/RUBELLA					
MMR - 2 doses required on or after first birthday	**Mo./day/year**	**Mo./day/year**			
VARICELLA					
Varicella - 2 doses	**Mo./day/year**	**Mo./day/year**			
OR					
Varicella Illness	**Date of Illness**				
HEPATITIS B					
Hepatitis B - 3 doses required	**Mo./day/year**	**Mo./day/year**	**Mo./day/year**		
INFLUENZA					
Influenza Name _____ Manufacturer_____	**Mo/Day/year**				

X_____ _____

Physician/Practitioner Signature **Date**

_____ _____

Physician/Practitioner Printed Name **Office Phone #**