HEALTH REPORT FORMS

 There are five (!) segments to the Health Report.

I. Health Report: Medical History

Fill this out and email it back.

II. Health Report: Immunization History

Fill this out and email it back.

III. Health Report: Meningitis immunization

Print out a hard copy of this Section III and give it to your doctor to fill out. Get it back from him and send it in (scan/email).

IV. Health Report: Physical exam & lab tests

Print out a hard copy of this Section IV and give it to your doctor to fill out. Get it back from him and send it in (scan/email). Note the lab tests which are required (see the tests printed in red). Please make sure your physician arranges for all these tests so that your admission review is not delayed. Send these in right away when you get them back (scan/ email).

V. Health Report: Eye exam

Print out a hard copy and give it to your ophthalmologist. Get it back from him and send it in (scan/email).

 When completed, scan/email to:

htsadmissions@holytrinityseminary.org

 It is wise to make a copy for yourself of all five reports. Your health report is personal and will not be released without your permission except for insurance purposes to your insurance company.

2017 HTS HEATLH REPORT

**I. Health Report:**

**Medical History**

**Personal Information, Contacts, and Insurance**

|  |
| --- |
| Date |
| **Personal Information**  |
| **Last Name, First Name, MI** | **Social Security #**  |
| Address |
| **City State Zip** |
| **Telephone** | **Cell Phone** | Date of Birth | Age |
| **Are you a veteran?**  **Yes No** | **Branch and Length of service** |  | **Citizenship** |  |
| Email Address |

|  |  |
| --- | --- |
| **Emergency Contacts** | **Parents/persons to be contacted in case of an emergency.****Please list two contacts.** |
| **1. Name** | Relationship | **Home Phone** |
|  **Address** | **Indicate Cell or Work phone** |
| **2. Name** | Relationship | **Home Phone** |
|  **Address** | **Indicate Cell or Work phone** |

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| --- |
| PRIMARY CARE PHYSICIAN |
| Address | Phone |
|  | Fax |
| **Insurance Information** | **Complete data below. Note: you also must attach copies of both sides of your insurance and prescription cards.** |
| Insurance Co. Name |  | Member Benefits Phone Number |
| **Address (to send claims)** |  |  |
|  City State Zip  |
| I.D. # | **Group #.** |
| **Insured’s Name (policyholder/responsible party)** | **Insured’s SS#** | Insured’s Birth Date | Relationship to Insured **Child Spouse Other** |
| **Prescription Card Name** | **Sponsor #** | **Card Member #** | **Customer Service Phone #** |

**Personal History**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **HAVE YOU HAD?**  | **Yes** | **N0** | **HAVE YOU HAD?**  | **Yes** | **N0** |
| **Abdominal Pain, frequent** |  |  | **Bloody bowel movements** |  |  |
| **Change in bowel habits, recent** |  |  | **Constipation, frequent** |  |  |
| **Difficulty Swallowing** |  |  | **Diverticulitis** |  |  |
| **Gallbladder Disease** |  |  | **Hemorrhoids** |  |  |
| **Hepatitis** |  |  | **Indigestion/Heartburn** |  |  |
| **Loss of Appetite** |  |  | **Nausea/Vomiting, persistent** |  |  |
| **Ulcers** |  |  | **Allergies/Hay Fever** |  |  |
| **Asthma** |  |  | **Bronchitis** |  |  |
| **Pneumonia/Pleurisy** |  |  | **Shortness of Breath** |  |  |
| **Sinus Problems** |  |  | **Sore Throat, frequent** |  |  |
| **Tuberculosis** |  |  | **Anemia** |  |  |
| **Cancer** |  |  | **Chicken Pox** |  |  |
| **Fatigue, chronic** |  |  | **Measles** |  |  |
| **Mumps** |  |  | **Polio** |  |  |
| **Scarlet Fever** |  |  | **Weight Loss, recent** |  |  |
| **Anxiety/Nervousness** |  |  | **Depression** |  |  |
| **Mental Illness** |  |  | **Phobias** |  |  |
| **Sleeping Difficulties** |  |  | **Arthritis** |  |  |
| **Back Pain, recurrent** |  |  | **Bone Fracture** |  |  |
| **Leg Pains/Cramps** |  |  | **Muscle Weakness** |  |  |
| **Bladder Infection** |  |  | **Blood in Urine** |  |  |
| **Kidney Infection** |  |  | **Kidney Stones** |  |  |
| **Urethral Discharge** |  |  | **Urination at Night** |  |  |
| **Urine Infection** |  |  | **Venereal Disease** |  |  |
| **Blurred Vision** |  |  | **Corrective Lenses** |  |  |
| **Decreased Hearing** |  |  | **Ear Infections, frequent** |  |  |
| **Eye Infections, frequent** |  |  | **Glaucoma** |  |  |
| **Chest Pain** |  |  | **Heart Murmur** |  |  |
| **High Blood Pressure** |  |  | **Irregular Pulse** |  |  |
| **Palpitations** |  |  | **Phlebitis** |  |  |
| **Rheumatic Fever** |  |  | **Swollen Ankles** |  |  |
| **Varicose Veins** |  |  | **Diabetes** |  |  |
| **Gout** |  |  | **Thyroid Disease** |  |  |
| **Fainting Spells** |  |  | **Headaches, frequent** |  |  |
| **Headaches, migraine** |  |  | **Numbness/tingling** |  |  |
| **Seizures/Convulsions** |  |  | **Stroke** |  |  |
| **Tremor** |  |  | **Psoriasis** |  |  |
| **Rashes** |  |  | **Nose Bleeds, recurrent** |  |  |

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| --- |
| **Surgeries:** |
| **Hospitalizations:** |

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| --- |
| **List all prescription medications you currently are taking:** |
| **List all over-the-counter medications you currently are taking:** |
| **List all allergies to medications, latex, herbal products:** |
| **List all non-food allergies:** |
| **List in detail all food and dietary allergies; include any recommended substitutes:** |
| **List all diseases, illnesses, permanent disabilities and/or health concerns:** |
| **Are you currently being treated by a health care professional? If yes, explain:** |
| **Do you smoke? 🞏Yes 🞏No How much per day?** |
| **Do you have a history of alcohol abuse? 🞏Yes 🞏No** **If yes, how long:** |
| **Have you been in recovery/sobriety? 🞏Yes 🞏No** |
| **Do you have a history of drug abuse? 🞏Yes 🞏No** **If so, please list drugs:** **How long have you been off them?** |

**Family Medical History**

If a blood relative (parent, sibling, uncle, aunt, or grandparent) has had any of the following diseases or conditions, list their relationship to you next to the condition.

|  |  |  |  |
| --- | --- | --- | --- |
| Tuberculosis |  | Cancer |  |
| Stroke |  | Arthritis |  |
| Migraines |  | Gout |  |
| Mental Illness |  | Kidney Disease |  |
| Epilepsy |  | Glaucoma |  |
| Diabetes |  | Allergy |  |
| Heart Attack |  | Hypertension |  |

**Release**

*Please sign the following release:*

I give permission to the Seminary Rector to speak with my doctor regarding my medical condition and any additional statements and interpretation of my medical condition so that the Seminary might better ascertain my ability to undertake serious studies for the priesthood.

|  |  |
| --- | --- |
|  |  |
| **Signature**  | **Date** |
|  |
| **Signature of Witness** |

**II. Health Report:**

**Immunization History**

**Immunization History**

I. Required Immunizations

You can obtain your immunization records from your physician, previous school, or your personal health records. Students with incomplete immunization records will be ineligible to register.

Either fill out this form or attach your immunization records.

|  |  |
| --- | --- |
| Tetanus **(Td, DPT, Tdap, Boostrix)** | Provide most recent date: |

|  |  |
| --- | --- |
| MMR **(Measles, Mumps, Rubella)**ORMeasles Serology (blood work) | Provide most recent date: Date:Results: |

|  |  |
| --- | --- |
| **Polio** | **Provide most recent date:** |

|  |  |
| --- | --- |
| **TB**TB Titer Test(Testing to see if you had TB) | **Provide most recent date:****Date:** |

* **Meningitis** – For this one immunization, you **MUST** provide proof of vaccination to UD or HTS**.** See the next section for meningitis information and the form.

|  |
| --- |
| II. Recommended Immunizations *(not required)* |
| Hepatitis B Vaccine | **1.** | ***2.*** | **3.** |

**III. Health Report:**

**Meningitis Immunization**

**Meningitis Fact Sheet**

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| --- |
| Texas passed Senate Bill 819 on **May 22, 2009,** requiring all students wishing to reside in *university-owned housing* to provide either proof of vaccination for meningitis or a signed waiver requesting exemption after having received information on the risks associated with meningococcal disease and the availability and effectiveness of the vaccine. \*Note: Waiver is not acceptable at the University of Dallas or Holy Trinity Seminary. |

College students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, freshmen living in residence halls are found to have a six-fold increased risk for the disease. The American College Health Association recommends that college students, particularly freshmen living in residence halls, learn more about meningitis and vaccination. At least 70% of all cases of meningococcal disease in college students are vaccine preventable.

**What is meningococcal meningitis?** Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of 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.

**How is it spread?** Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing, or sharing items like utensils, cigarettes, and drinking glasses.

**What are the symptoms?** Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and confusion.

**Who is at risk?** Certain college students, particularly freshmen who live in residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates should also consider vaccination to reduce their risk for the disease.

**Can meningitis be prevented?** Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. Adverse reactions to the meningitis vaccine are mild and infrequent, consisting primarily of redness and pain at the injection site, and rarely, a fever. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals. It does not protect against viral meningitis.

**For more information:** To learn more about meningitis and the vaccine, visit the websites of the Centers for Disease Control and Prevention (CDC), [www.cdc.gov/ncidod/dbmd/diseaseinfo](http://www.cdc.gov/ncidod/dbmd/diseaseinfo), and the American College Health Association, [www.acha.org](http://www.acha.org).

|  |  |  |
| --- | --- | --- |
| Meningitis **(Meningococcal)** | **Date invalid without****proof: signature or****stamp of health care****provider** | **Date** |
|  |

***Note carefully: Vaccination must be within the last five years of the date of semester entry to UD and HTS.***

|  |
| --- |
| *STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**HOSPITAL / CLINIC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DATE OF VACCINATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SIGNATURE OF HEALTHCARE PROVIDER OR STAMPED IMMUNIZATION RECORD:* |

**IV. Health Report:**

**Physical Exam & Lab Tests**

**Physical Exam**

*Must be completed and signed by your Physician*

|  |  |
| --- | --- |
| **Name** | **DOB** |
|  Last First MI |  MM/DD/YYYY |
| **BP** | **P** | **T** | **R** | **Ht** | **Wt** |
| **General:** |
| **Head and Neck:** |
| **Chest/Lungs:** |
| **Heart:** |
| **Abdomen:** |
| **Genitalia:** |
| **Ano-Rectal & Prostate:** |
| **Lymph Nodes** | **Cervical** | **Auxiliary** | **Inguinal** |
| **Musculo-skeletal:** |
| **Neurological:** |
| **Skin:** |
| **\*\*\*Required Laboratory:** **CBC, Urinalysis, Fasting Chemistry 24, Serology (Syphilis and Gonorrhea tests—RPR Quantitative),** **Stool Guaiac, TB Test, HTLV-III antibody (AIDS test).**  **For patients over 35 years of age, Chest X-Ray and EKG are also required.** |
| **NOTE: The above required laboratory studies are in addition to any study indicated by History and Physical Examination.**  |

**Copies of all laboratory reports are to be included with this completed medical statement**

|  |  |
| --- | --- |
|  |  |
| **Signature of Physician** | **Date** |
|  |
| **Physician’s Name (Please Print or Type)** |
|  |
| **Address** |
|  |
| **City, State, Zip** |
|  |

**V. Health Report:**

**Eye Exam**

**Ophthalmological Evaluation**

*Must be completed and signed by your Ophthalmologist*

|  |  |
| --- | --- |
| 1. **Uncorrected Vision**
 | Right Eye / |
| Left Eye / |
| 1. **Best Corrected Visual Acuity**
 | Right Eye / |
| Left Eye / |
| 1. **Is there any evidence of ocular disease that would be chronic, progressive, or require frequent treatment or surgery?**
 | 🞏Yes 🞏No If yes, please explain: |
| 1. **Is there any limitation of vision that would preclude the applicant’s performance of college level near tasks?**
 | 🞏Yes 🞏No If yes, please explain: |
|  **Notes** |

|  |  |
| --- | --- |
|  |  |
| **Signature of Ophthalmologist** | **Date** |
|  |
| **Ophthalmologist Name (Please Print or Type)** |
|  |
| **Address** |
|  |
| **City, State, Zip** |