STUDENT HEALTH FORM

Office of the University Nurse
1000 Fisk Street
Brownwood, TX 76801
Office: (325) 649-8601 Fax: (325) 649-8819

Personal and Emergency Information

Student's Name ________________________Student ID ________________Sex ________Date of Birth __________

Address ________________________________City/State/Zip ____________________Phone______________

Mobile Phone _____________Citizenship ____________________Date of Enrollment: Year ________ Semester______

Person to Notify in an Emergency _______________________________Relationship ________________________

Home Phone ___________________Mobile Phone _________________________Work Phone ______________

Campus Attending (check one): ☐ Brownwood ☐ El Paso ☐ New Braunfels

Insurance Information

Do you have hospitalization insurance? ☐ Yes ☐ No Name of Company ____________ Policy Number ______ Group Number ________

Howard Payne University does not provide accident or health insurance. It is the responsibility of each student to secure his/her medical insurance.

Tuberculosis Test

TB tests are required for students who have traveled outside the United States within the past 12 months or who were born outside the United States. Negative test results must be presented to the University Nurse before students can begin classes or move in to campus housing.

Skin Test: Date Administered _____/_____/_____ Date Read _____/_____/_____ Result: Pos. / Neg.

Chest X-ray (if skin test is positive): Date Read _____/_____/_____ Result: Pos. / Neg.

Immunization Information

Immunizations Required by Texas Law:

DT/DTP/DTAP/TD: *List dates of all doses: (1)* ___/___/____ (2) ___/___/____ (3) ___/____/___ (4) ___/____/____ (*Last dose within 10 years*)

Measles, Mumps, and Rubella: *Suggested for all students born on or after January 1, 1957, two doses are recommended.*

MMR Dose #1: Date _____/_____/_____ MMR Dose #2: Date _____/_____/_____

OR Measles Only: Date _____/_____/_____

Polio: OPV or IPV: (1) ____/____/____ ***(2)*** ____/____/____ ***(3)*** ____/____/____ ***(4)*** ____/____/____

Varivax (Chickenpox Vaccine): Two doses required if given after age 13.

Dose #1: Date _____/_____/_____ Dose #2: Date _____/_____/_____ **OR** Disease: Date _____/_____/_____

Hepatitis B:

Dose #1: Date _____/_____/_____ Dose #2: Date _____/_____/_____ Dose #3: Date _____/_____/_____

For all students (new, transfer, or former) entering HPU after January 1, 2012:

Meningococcal Vaccine (circle one)**:**

MPSV or MCV4 Date Administered: ____/_____/_____ Booster dose Administered: _____/_____/_____

About the Meningococcal Vaccination Requirement:
On and after January 1, 2012, all first-time students, including transfer students, must present a certificate to the institution demonstrating they have been vaccinated against bacterial meningitis. A student may be exempt from the requirement if he or she presents a physician's certificate indicating the vaccination would injure the health of the student or if he or she signs an affidavit declining the vaccination due to reasons of conscience including religious belief. The latter provision does not apply during a public health emergency, terrorist attack, hostile military or paramilitary action or extraordinary law enforcement emergency. The bill exempts a student who is enrolled only in online or other distance education courses or who is 30 years of age or older. **New and former HPU students to whom this requirement applies will not be permitted to schedule classes until compliance with this law is demonstrated by submitting the necessary paperwork (i.e., shot record, state affidavit, or physician's certificate). The vaccination must have been received within five years. Additionally, if the dose was received prior to the student's 16th birthday, a booster dose is needed prior to first day of classes.**

Validated by *physician, public health clinic, or transcript from school records. White space to right can include stamp of facility.*

Signature ___________________ Title ____________________ Date _____________

Address ___________________ City/State/Zip ______________ Phone _____________

Attach Copies of Immunization Records of ALL ADDITIONAL VACCINES RECEIVED: Immunization dates may be authenticated at HPU by providing a copy of TB skin test results (if required) AND a copy of original immunization record, public high school immunization record, or proof of active military service. If copies are submitted, **please check carefully to be sure that all required immunizations are listed**.

Form Continued on Reverse

Student Personal History

*Please answer all questions. Comment on **all** positive answers in space below.*

Allergies to Medications: ☐ No known drug allergies ☐ Yes (circle below) **Food Allergies:** ☐ No known food allergies ☐ Yes (list)___________________________

If yes, circle all that apply: Penicillin Sulfa Codeine Aspirin Cortisone Iodine Other: ____

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Scarlet Fever			Frequent Depression			"Trick" Knee, Shoulder, etc.		
Measles			Worry or Nervousness			Back Problems		
German Measles			Recurrent Headaches			Tumor, Cancer, Cyst		
Mumps			Recurrent Colds			Jaundice		
Chicken Pox Date: / /			Head Injury with Unconsciousness			Stomach or Intestinal Trouble		
Malaria			Hay Fever, Asthma			Hepatitis B		
Gum or Tooth Trouble			Tuberculosis			Anorexia/Bulimia		
Sinusitis			Shortness of Breath			Gallbladder Trouble or Gallstones		
Eye Trouble			Migraine Headaches			Recurrent Diarrhea		
Ear, Nose, Throat Trouble			Diabetes			Rupture, Hernia		
Surgery:			Epilepsy			Recent Gain/Loss of Weight		
Appendectomy			Anemia			Dizziness, Fainting		
Tonsillectomy			Pain/Pressure in Chest			Weakness, Paralysis		
Hernia Repair			Chronic Cough			Venereal Disease		
Other:			Palpitations (Heart)			Albumen/Sugar in Urine		
Herpes Simplex 1			High/Low Blood Pressure			Frequent Urination		
Herpes Simplex 2			Rheumatic Fever or Heart Murmur			Alcohol/Drug Abuse		
Frequent Anxiety			Disease or Injury of Joints			Women only: Menstrual Problems		

A. Has your physical activity been restricted during the past five years? ☐ Yes ☐ No
B. Have you had difficulty with school, studies, or teachers? ☐ Yes ☐ No
C. Have you received treatment or counseling for a nervous condition, personality, and/or character disorder or emotional problem? ☐ Yes ☐ No
D. Have you had any illness or injury or been hospitalized other than already noted? ☐ Yes ☐ No
E. Have you been rejected for or discharged from military service because of physical, emotional, or other reasons? ☐ Yes ☐ No

Use additional sheet for more space if needed.

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List all prescription medications taken on a regular basis:

Name of Medication	Dosage	How Often Taken	Reason for Taking

Family History

	Age	State of Health	Occupation	Age at Death	Cause of Death	Have any Relatives had?	Yes	No	Relationship
Father						Tuberculosis			
Mother						Diabetes			
Brothers						Kidney Disease			
						Heart Disease			
						Arthritis			
						Mental Illness			
Sisters						Asthma, Hay Fever			
						Epilepsy, Convulsions			
						High Blood Pressure			
						Cancer			

Final Statement

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) was designed in 1996 to establish national standards of privacy to protect health information. HIPAA limits the use and release of individual, identifiable, health information, gives patients the right to access their medical records, restricts most disclosure of health information to the minimum needed for the intended purpose, and establishes safeguards regarding disclosure of records for certain public responsibilities, such as public health, research, and law enforcement. Improper use or disclosures of patient information under this rule are subject to criminal and civil sanctions.

I have read and acknowledge the Final Statement and I give authorization for release/disclosure of my health information as deemed necessary per Howard Payne University unless revoked in writing. If I feel my rights have been violated, I will contact the Assistant Vice President for Business and Human Resources at (325) 649-8012, Packer Administration Bldg. room 210.

By signing this worksheet, I/we certify that all parts of this form have been read and the information provided is complete and true.

Student Print ________________________ Student Signature ________________________ Date ______________

Parent/Guardian Print ____________________ Parent/Guardian Signature ____________________ Date ______________