

STUDENT HEALTH FORM

In addition to this form, all students taking six or more credits are required to complete the Online Insurance form at myuarts.uarts.edu/ahpins by August 1 (fall or summer) or January 1 (spring).

STUDENT INFO

THE FOLLOWING INFORMATION IS TO BE FILLED OUT BY THE STUDENT.

STUDENT ID NUMBER: _____ ENTRANCE DATE: FALL 20____ or SPRING 20____ or SUMMER 20____

MAJOR: _____ PROGRAM TYPE (circle one): Undergraduate Graduate ESL Exchange

Last Name	First Name	Middle
Date of Birth	Gender	Social Security Number
Home Address	City	
State	Zip Code	Country
Home Phone	Student Cell Phone	Student Email Address
Emergency Contact (Name)	Relationship	City/State/Zip
Emergency Contact Home Phone	Emergency Contact Cell Phone	

Are you living in a residence hall on campus? ☐ YES ☐ NO

HEALTH INSURANCE

The information below is kept on file in the Health Office and **does not** count as having completed the required Online insurance form. All students taking six or more credits must complete the **Online insurance form** which can be found at myuarts.uarts.edu/ahpins by the deadline of August 1 (fall or summer) or January 1 (spring). More information on page 6.

Name of Insurance Company	Type of Plan (PPO, HMO)
Insurance ID Number	Group Number
Insurance Company's Phone Number	Subscriber's Full Name
Subscriber's Date of Birth	Student's Relationship to Subscriber

FAMILY BACKGROUND

	Age	Health Issues	Occupation	Age of Death (If applicable)	Cause of Death
Parent/Guardian					
Parent/Guardian					

ALLERGY INFORMATION

Do you have any allergies?

☐ YES

☐ NO

Do you carry an EpiPen?

☐ YES

☐ NO

List all allergies (including food, medicine, etc.)

Additional Notes

THE FOLLOWING INFORMATION IS TO BE FILLED OUT BY THE STUDENT.

MEDICAL HISTORY

Please provide a brief explanation in the comments section below if marking **yes** on any of the following.

Gastrointestinal	YES	NO
Reflux/GERD		
Frequent Upset Stomach		
Irritable Bowel		
Other		

Genitourinary	YES	NO
Kidney Disease		
Bladder/Kidney Infections		
Painful Periods		
Irregular Periods		
Other		

Head	YES	NO
Eye Condition		
Glasses/Contacts		
Hearing Loss		
ENT Condition		
Concussion History		
Other		

Skin	YES	NO
Acne		
Eczema		
Other		

Musculoskeletal	YES	NO
Back Problems		
Arthritis		
Strains/Sprains		
Fracture History		
Other		

Neurological	YES	NO
Frequent Headaches		
Dizziness/Fainting		
Seizure Disorder		
Head Injury/Concussion		
Other		

Mental Health	YES	NO
Eating Disorder		
OCD		
Bipolar Disorder		
Anxiety/Depression		
Other		

Cardiovascular	YES	NO
High or Low Blood Pressure		
Anemia		
Arrhythmia		
Blood Clot History		
Other		

Respiratory	YES	NO
Asthma		
Pneumonia		
Chronic Cough		
Shortness of Breath		
Other		

Other
Please indicate if not noted above.
Other:

List medications you take on a regular basis. *Include prescriptions, OTCs, herbal, vitamin and dietary supplements.*

Comments/Additional Info:

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

UARTS ID: _____

REQUIRED PHYSICIANS ASSESSMENT FORM (within one year)

Date of Examination: _____ BP: _____ / _____ Pulse: _____ HEIGHT: _____ inches WEIGHT _____ lbs

Medication Allergies: _____

Current Medications: _____

	NORMAL	ABNORMAL	COMMENTS
Skin			
Ears, Eyes, Nose, Throat			
Mouth, Teeth, Gums			
Endocrine			
Respiratory			
Cardiac			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurological			
Emotional/Psychological			
Other Findings			

Additional Comments: _____

Recommendation for physical activities (including our vigorous performing arts programs): ☐ UNLIMITED ☐ LIMITED*

The student is able to meet the physical and emotional demands of college life: ☐ YES ☐ NO*

* Please provide an explanation if choosing this option:

PHYSICIAN INFORMATION

Physician's Name (Printed): _____

Telephone: _____

Address: _____

Fax: _____

 Physician Signature and Date (REQUIRED): _____

Physician's Stamp: _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

REQUIRED IMMUNIZATIONS

Visit uarts.edu/healthservices to learn more about each immunization.

SARS-CoV-2 (Novel Coronavirus) <hr/> Full dose administered two weeks prior to arrival non campus to show immunity	Dose 1 ____/____/____ MM/DD/YY Manufacturer _____	Dose 2 (if applicable) ____/____/____ MM/DD/YY Manufacturer _____	Dose 3 (Booster Dose) ____/____/____ MM/DD/YY Manufacturer _____
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Measles, Mumps, Rubella <hr/> Two doses of vaccine or a blood test showing immunity.	OR	MMR Dose 1 ____/____/____ MM/DD/YY	OR	Measles Dose 1 ____/____/____ MM/DD/YY	Mumps Dose 1 ____/____/____ MM/DD/YY	Rubella Dose 1 ____/____/____ MM/DD/YY
Measles Antibody month _____ year _____ result: positive (yes) or (no)		MMR Dose 2 ____/____/____ MM/DD/YY		Measles Dose 2 ____/____/____ MM/DD/YY	Mumps Dose 2 ____/____/____ MM/DD/YY	Rubella Dose 2 ____/____/____ MM/DD/YY
Mumps Antibody month _____ year _____ result: positive (yes) or (no)						
Rubella Antibody month _____ year _____ result: positive (yes) or (no)						

Meningococcal* <hr/> *(serogroups A, C, Y and W-135) Two doses of the vaccine. Note: Students must have received a dose on or after the age of 16 to be considered fully immunized.	Meningococcal Dose 1 ____/____/____ MM/DD/YY	Meningococcal Dose 2 ____/____/____ MM/DD/YY	Please specify vaccine type (or serogroups): (Menactra, Menveo, Mencevax, etc.) _____ _____ _____
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RECOMMENDED IMMUNIZATIONS

Visit uarts.edu/healthservices to learn more about each immunization.

Meningococcal* <hr/> *(serogroups B) Two doses of the vaccine. Note: Students must have received a dose on or after the age of 16 to be considered fully immunized.	MenB-RC Dose 1 (Bexsero) ____/____/____ MM/DD/YY	OR	MenB-FHbp Dose 1 (Trumenba) ____/____/____ MM/DD/YY	MenB-FHbp Dose 2 (Trumenba) ____/____/____ MM/DD/YY	MenB-FHbp Dose 3 (Trumenba) ____/____/____ MM/DD/YY
	MenB-RC Dose 2 (Bexsero) ____/____/____ MM/DD/YY				

Influenza <hr/>	Administered On ____/____/____ MM/DD/YY Manufacturer _____	Lot# _____	Expiration Date ____/____/____ MM/DD/YY
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THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

RECOMMENDED IMMUNIZATIONS

Visit uarts.edu/healthservices to learn more about each immunization.

Polio <hr/> OPV alone (oral Sabin three doses)		Dose 1 ____/____/____ MM/DD/YY	Dose 2 ____/____/____ MM/DD/YY	Dose 3 ____/____/____ MM/DD/YY
IPV/OPV sequential	IPV 1 ____/____/____ MM/DD/YY	IPV 2 ____/____/____ MM/DD/YY	OPV 1 ____/____/____ MM/DD/YY	OPV 2 ____/____/____ MM/DD/YY

Varicella (Chicken Pox) <hr/> Two doses of the vaccine or history of illness or blood test showing immunity. Varicella Antibody month _____ year _____ result: positive (yes) or (no)	Varicella Dose 1 ____/____/____ MM/DD/YY	Varicella Dose 2 ____/____/____ MM/DD/YY	OR	Varicella Illness ____/____/____ MM/DD/YY
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Hepatitis B <hr/> Three doses of vaccine or a blood test showing immunity. Hepatitis B Surface Antibody month _____ day _____ year _____ result: reactive _____ non-reactive _____	Hepatitis Dose 1 ____/____/____ MM/DD/YY	Hepatitis Dose 2 ____/____/____ MM/DD/YY	Hepatitis Dose 3 ____/____/____ MM/DD/YY
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Hepatitis A <hr/> Two doses of vaccine or a blood test showing immunity. Hepatitis A Surface Antibody month _____ day _____ year _____ result: reactive _____ non-reactive _____	Hepatitis Dose 1 ____/____/____ MM/DD/YY	Hepatitis Dose 2 ____/____/____ MM/DD/YY
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HPV (Human Papillomavirus) <hr/> <input type="checkbox"/> HPV4 <input type="checkbox"/> HPV9	HPV Dose 1 ____/____/____ MM/DD/YY	HPV Dose 2 ____/____/____ MM/DD/YY	HPV Dose 3 ____/____/____ MM/DD/YY
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Tetanus-Diphtheria & Pertussis <hr/> <i>(Tdap)</i> Td alone does not satisfy this requirement.	Tdap ____/____/____ MM/DD/YY	Td (booster) ____/____/____ MM/DD/YY	Td booster is required if Tdap is older than 10 years.
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Use this section to list additional vaccinations. Please include the date administered as well as any relevant information.

Other List Vaccine Name:	Dose 1 ____/____/____ MM/DD/YY	Dose 2 ____/____/____ MM/DD/YY	Dose 3 ____/____/____ MM/DD/YY
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Other List Vaccine Name:	Dose 1 ____/____/____ MM/DD/YY	Dose 2 ____/____/____ MM/DD/YY	Dose 3 ____/____/____ MM/DD/YY
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THE FOLLOWING INFORMATION IS TO BE FILLED OUT BY THE STUDENT.

HEALTH FORM CONFIRMATION

THIS FORM HAS BEEN COMPLETED TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE:

Student Name (Printed):

Date:

▶ Student Signature:

PRIVACY NOTICE AND AUTHORIZATION

Our office is dedicated to preserving the privacy of your individual health information and will maintain its strict confidentiality. Information will not be released without authorization from you, the student.

Sign below if, at this time, you consent to the release of information to your parents/legal guardian regarding your general health and medical attention. Note: you may choose to revoke this authorization at any time by contacting Health Services.

Student Name (Printed):

Date:

▶ Student Signature:

INSURANCE REQUIREMENT & CONTACT

In addition to the health forms, students are required to complete the Online insurance form at myuarts.uarts.edu/ahpins. Information provided on this health form does not count as proof of insurance.

Opting OUT of the School Insurance: Note that the school insurance fee is automatically included on every student's tuition bill. In order to remove this fee, *you must enter your personal insurance information at myuarts.uarts.edu/ahpins before the start of classes.* Failure to opt out prior to the end of drop/add will result in manual enrollment in the school plan and the student will be responsible for the cost of the student health plan, no exceptions.

Opting INTO the School Insurance: If you wish to enroll in the school plan you must visit myuarts.uarts.edu/ahpins and confirm enrollment prior to August 1st (if starting in the fall or summer) or January 1st (spring) in order to begin coverage on-time. Doing nothing, or waiting until after the above dates, will result in late enrollment and may involve a lapse of coverage.

To learn about the school-sponsored plan please visit uarts.myahpcare.com.

To read more about our requirements, services provided, and useful information for first-time students please visit our FAQ page at uarts.edu/healthservices

Please contact Health Services at 215.717.6652 or healthservices@uarts.edu with any questions.

SUBMITTING THE HEALTH FORM:

PLEASE RETAIN A COPY OF THE COMPLETED FORMS FOR YOUR RECORDS.

The Student Health Form is comprised of six pages, two of which need to be completed by your physician (see: pages 3–5). All pages must be completed and submitted at one time to Health Services by **August 1** (if starting in the fall or summer) or **January 1** (if starting in the spring). We will accept any of the following methods of submission:

By Mail:

University of the Arts
ATTN: Health Services
320 S. Broad St.
Philadelphia, PA 19102-9762

Electronically*:

Students may scan and attach a **SINGLE PDF**** of the health forms to healthservices@uarts.edu.

* If sending by fax/electronically: bring the original documents with you to school, to be collected by Health Services during Orientation.

** We absolutely cannot accept pictures of documents taken by phone or similar. Only a single PDF scan will be accepted for review.

Starting in May (for Fall) and November (for Spring), forms that are properly submitted are due to be processed within 48 business hours of their receipt. Upon review, students will be contacted via their **UArts email address** regarding any incomplete information.

VISIT [UARTS.EDU/HEALTHSERVICES](https://uarts.edu/healthservices) FOR HELP ON HOW TO CORRECTLY UPLOAD YOUR HEALTH FORMS AND FOR MORE INFORMATION.

PART I: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

(to be completed by incoming students)

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you ever had close contact with persons known or suspected to have active TB disease?

☐ YES

☐ NO

Were you born in one of the countries or territories identified as having a high incidence of active TB disease by the World Health Organization (WHO)? (If yes, please list the country below)

☐ YES

☐ NO

For a complete and updated listing of affected countries, please visit www.who.int/tb for more information.

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Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

Have you had frequent or prolonged visits* to one or more countries or territories with a high prevalence of TB disease? (If yes, please list the country below)

☐ YES

☐ NO

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?

☐ YES

☐ NO

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?

☐ YES

☐ NO

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

☐ YES

☐ NO

If the answer is YES to any of the above questions continue to pages 8 and 9. UArts requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

If the answer to all of the above questions is NO, no further testing or further action is required.

**The significance of the travel exposure should be discussed with a health care provider and evaluated.*

PART II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I.

Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below)

☐ YES

☐ NO

History of BCG vaccination? (If yes, consider IGRA if possible.)

☐ YES

☐ NO

1. TB SYMPTOM CHECK

Does the student have signs or symptoms of active pulmonary tuberculosis disease?

☐ YES

☐ NO

If no, proceed to section two or three.

If yes, check below:

- ☐ Cough (especially if lasting for three weeks or longer) with or without sputum production
- ☐ Coughing up blood (hemoptysis)
- ☐ Chest pain
- ☐ Loss of appetite
- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. TUBERCULIN SKIN TEST (TST)

(TST result should 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: ____/____/____
M D Y

Date Read: ____/____/____
M D Y

Result: _____ mm of induration

**Interpretation: positive _____ negative _____

Date Given: ____/____/____
M D Y

Date Read: ____/____/____
M D Y

Result: _____ mm of induration

**Interpretation: positive _____ negative _____

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

>The significance of the travel exposure should be discussed with a health care provider and evaluated.

3. INTERFERON GAMMA RELEASE ASSAY (IGRA)

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

Result: positive____ negative____ indeterminate____ borderline____ (T-Spot only)

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

Result: positive____ negative____ indeterminate____ borderline____ (T-Spot only)

4. CHEST X RAY: (REQUIRED IF TST OR IGRA IS POSITIVE)

Date Obtained: ____/____/____ Result: normal ____ abnormal ____
M D Y

PART III. Management of Positive TST or IGRA

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. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ☐ Infected with HIV
- ☐ Recently infected with *M. tuberculosis* (within the past 2 years)
- ☐ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ☐ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ☐ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ☐ Have had a gastrectomy or jejunioileal bypass
- ☐ Weigh less than 90% of their ideal body weight
- ☐ Cigarette smokers and persons who abuse drugs and/or alcohol

____ Student agrees to receive treatment

____ Student agrees to receive treatment

Health Care Professional Signature

Date