UNIVERSITY OF THE Arts

STUDENT HEALTH FORM

In addition to this form, all students taking six or more credits are required to complete the online insurance form available at uarts.edu/health-forms 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** 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					

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ALLERGY INFORMATION

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

Do you have any allergies? ☐ YES ☐ NO **Do you carry an EpiPen?** ☐ YES ☐ NO

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

Additional Notes

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:

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Last Name First Name Middle

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

DOB:_____

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:

_____ / /

University of the Arts | Office of Health Services
Attn: UArts Health Services | 320 S. Broad St. | Philadelphia, PA | 19102
p: 215-717-6652
healthservices@uarts.edu

Continues on other side.

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

REQUIRED IMMUNIZATIONS

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

Measles, Mumps, Rubella

Two doses of vaccine or a blood test showing immunity.

Measles Antibody month _____ year _____
result: positive (yes) ☐ or (no) ☐

Mumps Antibody month _____ year _____
result: positive (yes) ☐ or (no) ☐

Rubella Antibody month _____ year _____
result: positive (yes) ☐ or (no) ☐

OR

MMR Dose 1
___/___/___
MM/DD/YY

MMR Dose 2
___/___/___
MM/DD/YY

OR

Measles Dose 1 ___/___/___ MM/DD/YY
Mumps Dose 1 ___/___/___ MM/DD/YY
Rubella Dose 1 ___/___/___ MM/DD/YY

Measles Dose 2 ___/___/___ MM/DD/YY
Mumps Dose 2 ___/___/___ MM/DD/YY
Rubella Dose 2 ___/___/___ MM/DD/YY

Meningococcal*

*(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.)
_____
_____
_____

RECOMMENDED IMMUNIZATIONS

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

SARS-CoV-2 (Novel Coronavirus)

Full dose administered two weeks prior to arrival on 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 _____

Meningococcal*

*(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

MenB-RC Dose 2 (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

Influenza

Administered On
___/___/___
MM/DD/YY

Lot#
_____

Expiration Date
___/___/___
MM/DD/YY

Manufacturer
_____

Continues on next page.

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY ADVANCED PRACTITIONER

RECOMMENDED IMMUNIZATIONS

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

Polio

OPV alone
(oral Sabin three doses)

Dose 1	Dose 2	Dose 3
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

IPV/OPV sequential

IPV 1	IPV 2	OPV 1	OPV 2
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

Varicella (Chicken Pox)

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	Varicella Dose 2	*OR*	Varicella Illness
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY		___/___/___ MM/DD/YY

Hepatitis B

Three doses of vaccine ***or*** a blood test showing immunity.

Hepatitis B Surface Antibody
month _____ day _____ year _____
result: reactive _____ non-reactive _____

Hepatitis Dose 1	Hepatitis Dose 2	Hepatitis Dose 3
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

Hepatitis A

Two doses of vaccine ***or*** a blood test showing immunity.

Hepatitis A Surface Antibody
month _____ day _____ year _____
result: reactive _____ non-reactive _____

Hepatitis Dose 1	Hepatitis Dose 2
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

HPV (Human Papillomavirus)

☐ HPV4 ☐ HPV9

HPV Dose 1	HPV Dose 2	HPV Dose 3
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

Tetanus-Diphtheria & Pertussis

(Tdap)
Td alone does not satisfy this requirement.

Tdap	Td (booster)	
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	Td booster is required if Tdap is older than 10 years.

Use this section to list additional vaccinations. Please include the date administered as well as any relevant information.

Other
List Vaccine Name:

Dose 1	Dose 2	Dose 3
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ MM/DD/YY

Other
List Vaccine Name:

Dose 1	Dose 2	Dose 3
___/___/___ MM/DD/YY	___/___/___ MM/DD/YY	___/___/___ 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 **available at** uarts.edu/health-forms. 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* 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 submit the online insurance form 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 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 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.lnt/tb for more information.

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 jejunoileal 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