



NOTE: A STUDENT MAY NOT REGISTER FOR CLASSES UNTIL THIS FORM IS PROPERLY COMPLETED AND SUBMITTED TO THE STUDENT HEALTH SERVICE.

Rice University - Student Health Data Form

Last Name _____ First Name _____ Middle _____
 Date of Birth _____ Place of Birth _____ Sex (F / M) Marital Status _____
 Social Security# _____ Department (Graduate students) _____
 Address _____
 Telephone # _____ E-mail _____

In Case of EMERGENCY, Please contact _____ telephone# _____
 Relationship _____

STUDENT ID # _____

IMPORTANT INSTRUCTIONS ABOUT THIS FORM

1. THIS HEALTH DATA FORM IS REQUIRED OF ALL FULL-TIME STUDENTS.
 Please complete the front page and section I. Then take this form to your doctor.
 The examining physician must complete sections II, III, & IV.
2. * **A STUDENT WILL NOT BE ALLOWED TO REGISTER FOR CLASSES UNTIL THIS FORM IS PROPERLY COMPLETED AND SUBMITTED TO THE STUDENT HEALTH SERVICE.** *
3. **SUBMITTED FORMS WILL BE CONSIDERED INCOMPLETE IF,**
 - a. THE IMMUNIZATION SECTION DOES NOT DOCUMENT THE REQUIRED VACCINATIONS.
 - b. TB SKIN TESTING HAS NOT BEEN PERFORMED, INTERPRETED, AND DOCUMENTED
 - c. THE PHYSICAL EXAM SECTION HAS NOT BEEN COMPLETED BY A LICENSED MEDICAL PRACTITIONER
 - d. THERE ARE OTHER MISSING OR INCOMPLETE DATA
4. **THIS FORM MUST BE RECEIVED BY JULY 1ST (DECEMBER 1ST FOR SPRING SEMESTER). AFTER THIS DATE THERE IS A \$30 LATE FEE.**
5. Please make a copy of this form and retain for your records. Bring this copy with you.
6. Completed forms should be mailed to,

RICE UNIVERSITY STUDENT HEALTH SERVICE
6100 MAIN ST. MS#760
HOUSTON, TX 77005 USA
7. DO NOT FAX THIS FORM OR SEND ELECTRONICALLY.
- 8 Immunizations, TB skin testing, and the physical examination must be completed prior to arrival at Rice University. The Rice Student Health Service will not perform these functions.
9. If a student is under age 18 as of the first day of orientation week please fill out the parental consent form and have it notarized. (form available on web site, www.rice.edu/health)

ADDITIONAL INFORMATION.

This form may be obtained online at, <http://www.rice.edu/health>
 Answers to frequently asked questions regarding this form may be found at the above web page.
 Additional questions should be directed to hlsv@rice.edu, or (713) 348-4966



Section I. Health History (A) - please put a check mark in the box to indicate if there is a history of any of the following conditions. Note: the examining physician must comment fully on any checked response.

1	<input type="checkbox"/>	allergies / hay fever	14	<input type="checkbox"/>	eye disease or injury	27	<input type="checkbox"/>	mononucleosis (EBV)
2	<input type="checkbox"/>	anemia	15	<input type="checkbox"/>	migraines or frequent headaches	28	<input type="checkbox"/>	pneumonia
3	<input type="checkbox"/>	anxiety	16	<input type="checkbox"/>	gastrointestinal disorder	29	<input type="checkbox"/>	parasites
4	<input type="checkbox"/>	arthritis	17	<input type="checkbox"/>	heart disease	30	<input type="checkbox"/>	chicken pox (varicella)
5	<input type="checkbox"/>	asthma	18	<input type="checkbox"/>	heart murmur	31	<input type="checkbox"/>	measles (rubeola)
6	<input type="checkbox"/>	back or neck problems	19	<input type="checkbox"/>	hepatitis	32	<input type="checkbox"/>	HIV
7	<input type="checkbox"/>	bleeding or clotting disorders	20	<input type="checkbox"/>	high blood pressure	33	<input type="checkbox"/>	German measles (rubella)
8	<input type="checkbox"/>	bone or joint problems	21	<input type="checkbox"/>	hospitalization(s)	34	<input type="checkbox"/>	typhoid fever
9	<input type="checkbox"/>	cancer	22	<input type="checkbox"/>	inflammatory bowel disease	35	<input type="checkbox"/>	cholera
10	<input type="checkbox"/>	depression	23	<input type="checkbox"/>	kidney disease	36	<input type="checkbox"/>	Sickle cell disease or trait
11	<input type="checkbox"/>	diabetes	24	<input type="checkbox"/>	malaria / tropical diseases	37	<input type="checkbox"/>	sexually transmitted disease
12	<input type="checkbox"/>	eating disorder	25	<input type="checkbox"/>	neurological disease	38	<input type="checkbox"/>	surgery (any)
13	<input type="checkbox"/>	disease of mouth, teeth, or gums	26	<input type="checkbox"/>	psychiatric illness	39	<input type="checkbox"/>	tuberculosis

40. Have you ever passed out during or after exercise? Yes No
41. Have you ever had chest pain during or after exercise? Yes No
42. Have you ever had unusual shortness of breath or fatigue during or after exercise? Yes No
43. Have any family members or relatives died of heart problems or of sudden death before age 50? Yes No
44. **Females only:** Are your menstrual cycles... regular irregular (*please comment*) _____

(B) - Lifestyle Variables

- Do you use tobacco? No Yes - *If yes please indicate type and amount per day (week)* _____
- Do you exercise? No Yes - *If yes please indicate activity* _____
How many days per week? _____ *Hours per week?* _____
- Do you drink alcohol? No Yes *If yes please indicate amount and frequency* _____
- Do you wear seat belts in the car? No Yes
- Do you follow a specific diet or are there any dietary restrictions? No Yes - *List* _____
- Do you take any supplements or herbal medications? No Yes - *List* _____

(C) - Family Medical History

Do any family members have any health problems or medical conditions? No Yes (*please indicate*) _____

The following sections are to be completed by the examining physician

*To the examining physician, the student has already been accepted to Rice University. The information on this form will become part of the student's confidential medical record maintained by the Student Health Service.
 Please fully complete Sections II, III, and IV*

Section II. (A) - Please review the health history (sec. I (A) - above) and comment fully on **all** positive responses the student has indicated (attach separate sheet(s) if needed)

NAME _____ DATE _____

(B) Is the student currently using any medication(s)?

None Yes (please list below, indicating dosage and reason for treatment)

(C) Is the student allergic to any medication(s)? None Known Yes (please list and describe reaction)

Section III. - Immunizations & TB skin testing

A.) Required Immunizations

Immunization	Requirements	Date 1	Date 2	Date 3	Date 4	Date 5
Diphtheria - Tetanus (dT)	Must have completed primary series and received last booster within 10 years					
		list any additional boosters				

Immunization	Requirements	Date 1	Date 2
Mumps, Measles, and Rubella (MMR)	Must have received two vaccinations, OR submit blood antibody titers documenting immunity to these diseases (attach copy of lab results)		

Immunization	Requirements	Date 1	Date 2	Date 3	Date 4	Date 5
Polio	Must have completed primary series					

B.) Required Tuberculosis (TB) Testing (complete guidelines can be found at www.cdc.gov)

Skin testing must be done on all students within 6 months prior to the first day of classes. Prior inoculation with BCG in childhood does NOT preclude TB skin testing. The skin test administered must be PPD (Mantoux). For international students it is recommended that TB skin testing be done at a United States public health clinic (city, county, or state Health Department).

Date PPD administered	Date read	Result (mm induration)

If a student tests positive then a chest x-ray should be performed and the box to the right completed.

If a student has previously tested positive then a chest x-ray is required. The chest radiograph must be within 6 months prior to the first day of classes. Also, attach documentation stating how this was addressed (dates, radiographic report, and treatment given).

Complete this boxed section only if skin test is positive		
Date of chest radiograph	Findings	Radiologist
Please indicate proposed clinical management		

Signature of medical professional verifying immunizations and TB testing _____

C.) Optional Immunizations

1	Meningococcal Meningitis	First year on-campus college students have increased risk of contracting meningococcal meningitis. The ACIP recommends that college students be made aware of this disease and given the opportunity to become vaccinated.
Initial here if you have counseled the student. _____		Date of vaccination _____

2	Hepatitis B	Date 1	Date 2	Date 3

3	Chicken Pox (Varicella)	Date 1	Date 2

4	Hepatitis A	Date 1	Date 2

5	HPV	Date 1	Date 2	Date 3

Section IV. Physical Examination NAME _____

Height _____ Weight _____ Body Mass Index $\left[\frac{\text{weight (kg)}}{\text{height (m)}^2} \right] = \underline{\hspace{2cm}}$ normal 18.5 - 25
 obese ≥ 30
 Blood Pressure _____ Pulse _____
 Vision (uncorrected) - Right ___/___ Left ___/___ Both ___/___
 (with best correction) - Right ___/___ Left ___/___ Both ___/___

System	Normal	Please comment on any abnormal findings
Eyes		
Ears		
Nose		
Mouth / Throat		
Dental		
Neck		
Respiratory		
Heart		
Peripheral pulses		
Abdomen		
Skin		
Genito-urinary		
Neurological		
Emotional		
Psychiatric		
Back		
Musculoskeletal		

Please attach copies of any laboratory tests you feel are indicated

To the examining physician, Rice University is a rigorous, challenging academic institution. We ask that you consider how this might affect the student's current state of health.

- Does the student have any medical, emotional or psychiatric conditions that would interfere with functioning in a stressful environment? No Yes
- Does the student have any cardiovascular disease that would limit their full participation in sports? No Yes
- Are there any other conditions that would preclude physical training or competition in sports? No Yes
- Is the student currently being treated for any medical or psychiatric condition? No Yes
- Is the student underweight or overweight? No Yes

If you answered yes to any question above please comment below. Attach or send a separate letter if needed

Name of examining *physician _____ *note- must not be student's parent
 Address _____
 telephone # _____

Signature _____
 Date _____