PROVIDENCE COLLEGE | STUDENT HEALTH CENTER

THIS PAGE IS FOR YOUR RECORDS. PLEASE DO NOT RETURN WITH HEALTH FORM.

Health Record Checklist:

☐ I am aware that if I am a recent PC graduate and have health records on file at the Student Health Office, I do not need to complete these forms.

OR

☐ I completed the College health form.

☐ I provided a recent physical exam (EMR acceptable) dated after April 1st, 2019.

☐ I provided up to date immunizations required by the RIDOH (EMR acceptable).

☐ I completed and signed the TB questionnaire.

☐ I supplied a copy of the front and back of my insurance card.

☐ I have checked to see what my private insurance company will cover in Rhode Island.

☐ I am aware that per the Rhode Island Department of Health, students who have not submitted documentation for the required immunizations and TB questionnaire will NOT be permitted on campus and cannot work as graduate assistants. This policy is strictly enforced by the College.

Thank you,

Student Health Center Staff (Questions? call: 401-865-2422)

Completed Health Records Can Be Mailed or Emailed To:

Mr. Todd Hopkins
thopkin2@providence.edu
Providence College
Coordinator of Graduate Assistants
Feinstein 301
One Cunningham Square
Providence, RI 02918-0001

PROVIDENCE COLLEGE | STUDENT HEALTH CENTER

DUE DATE
Aug. 1, 2021

Mail Forms To: Providence College
Coordinator of Graduate Assistants
Feinstein 301
One Cunningham Square
Providence, RI 02918-0001

PERSONAL & CONFIDENTIAL
PLEASE PRINT OR TYPE

Questions? Call us at 401-865-2422

Per the Rhode Island Department of Health, students who have not submitted documentation for the required immunizations and TB questionnaire will NOT be permitted on campus.

Name: _____
Last First MI

Date of Birth: _____ Banner ID #: 00 _____

Home Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____

HEALTH INSURANCE COVERAGE: YOU MUST INCLUDE A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD WITH THIS FORM.

It is the responsibility of each student to understand the requirements of his/her medical coverage.

1. Does your insurance coverage require pre-authorization: ☐ YES ☐ NO
2. Does your insurance company cover you in the State of Rhode Island? ☐ YES ☐ NO

Insurance Carrier: _____ Phone: _____

Address: _____
Street City State Zip

Policy Number: _____ Group #: _____

Name of Principal Insured: _____ Employer of principal insured: _____

HAVE YOU APPLIED FOR INSURANCE COVERAGE THROUGH UNIVERSITY HEALTH PLANS? ☐ YES ☐ NO

If yes, your membership card will be available online for you to print and carry after the start of the 2018-19 academic year.

EMERGENCY CONTACTS

_____
Name Address

_____
Phone Relationship to Student

_____
Name Address

_____
Phone Relationship to Student

Student Name:_____Date of Birth: _____

IMMUNIZATION RECORD Please attach an EMR vaccination form or have your at home provider fill out and sign below.

REQUIRED IMMUNIZATIONS

Hepatitis B 3 doses required	Date of Dose #1:	Date of Dose # 2:	Date of Dose #3:
or **Hepatitis B Titer**	☐ pos ☐ neg - attach report Date:		
MMR (Measles, Mumps, Rubella) 2 doses required or individual vaccines as listed below	Date of Dose #1: Given at 12 months after birth or later	Date of Dose #2: Given at least 1 month after first dose	
Measles (Rubeola) Students born prior to 1957 are required to have at least one dose	Date of Dose #1:	Date of Dose #2:	or Record of Titer -attach report ☐ pos ☐ neg Date:
Mumps Required for all students regardless of age	Date of Dose #1: Immunized with live vaccine at 12 months after	Date of Dose #2: Given at least 1 month after the first dose	or Record of Titer –attach report ☐ pos ☐ neg Date:
Rubella (German Measles) Required for all students regardless of age	Date of Dose #1: Immunized with live vaccine at 12 months after	Date of Dose #2: Given at least 1 month after the first dose	or Record of Titer – attach report ☐ pos ☐ neg Date:
Meningococcal Vaccine (A, C, Y, W-135) Required if under 22 years old	☐ Menactra ☐ Menomune ☐ Menveo ☐ Other:	Date of Dose #1	Date of Booster Dose: **Required if dose 1 was given before 16 years old**
Tdap (Tetanus-Diphtheria- Pertussis) Must be within the past 10 years	Date of Dose:		
Varicella (Chicken Pox) History of disease or 2 doses required or positive titer	Date of Dose # 1: Date of Dose # 2:	or History of Disease Date:	or Record of Titer – attach report ☐ pos ☐ neg Date:

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Address: _____
Street City State Zip

Phone:_____Fax: _____

Student Name:_____ Date of Birth: _____

TUBERCULOSIS (TB) SCREENING FORM – **STUDENT** and **PROVIDER'S** signatures required.

To help us determine if you need to have a TB (Tuberculosis) skin test or TB blood test (IGRA, TB Quantiferon Gold, TB-spot) before coming to Providence College, you must answer the following questions and provide your signature/appropriate documentation at the end of the section.

1. Were you born in one of the following areas: Africa, Asia, Philippines, Indonesia, Eastern Europe, Latin America, Mexico, Portugal, Caribbean, or the Middle East?	YES ☐ NO ☐
2. Have you lived in or had extensive travel to a high prevalence area (listed above)?	YES ☐ NO ☐
3. Have you worked or lived in a potentially high risk setting such as a prison, a long term care facility, a homeless shelter, a residential facility for persons with HIV/AIDS or a drug treatment center?	YES ☐ NO ☐
4. Have you had recent close or prolonged contact with someone with infectious TB?	YES ☐ NO ☐
5. Do you or anyone living in your household have a history of intravenous or other street drug use, or HIV infection/AIDS?	YES ☐ NO ☐
6. Have you ever had a documented positive TB skin test or history of active TB infection?	YES ☐ NO ☐

*If you answered **No** to all of the above questions (1 – 6), no further testing or further action is required. Please sign below, and send this form with your immunization record to Health Services.*

*If you answered **Yes** to any of the first 5 questions and **No** to question 6, then you are required to have a PPD skin test or TB blood test (IGRA, TB Quantiferon Gold, TB-spot) within 6 months prior to the start of classes. The PPD skin test or IGRA **must be performed in the U.S.** Please sign below and have your provider document the results of your testing.*

*If you answered **Yes** to question 6, then you do not need to be retested, but must provide documentation of a negative chest x-ray done in the U.S (within 6 months prior to the start of classes), and documentation of any medication and treatment for your positive TB test. Please include documentation with this form and sign form below.*

***Student Signature**:_____ **Date:**_____*

TB (TUBERCULIN) SKIN TEST and TB blood test must be performed in the U.S. and documentation is to be attached to this form. TB skin test and/or TB blood test is only required if you answered "yes" to any of the first 5 questions above.

Date TB Skin Test Given: _____

Date TB Skin Test Read (within 48-72 hours): _____

Results *(must be recorded in mm of induration; if no induration, write "0"):*_____mm

IGRA must be performed in the U.S.: TB Quantiferon Gold ☐ TB spot ☐

Result: Positive ☐ Negative ☐ Indeterminate ☐

Chest X-ray *(Required if tuberculosis test is positive):* Date:_____

Result: Normal ☐ Abnormal ☐

Dates of Treatment for Latent or Active TB: _____

Provider Name (*please print*): _____

Provider Signature (*required*): _____

Phone:_____ Fax: _____