ORU MAKE NO LITTLE PLANS HERE

MEDICAL ASSESSMENT & IMMUNIZATION INFORMATION

For Office Use Only

Student Health Requirements

As part of the admissions process for Oral Roberts University, students are required to provide a completed Medical Assessment which includes a Medical History, a Physical Examination, Physician's Recommendations for Exercise, and Immunization Record. All responses must be in English. The Medical Assessment must be dated one year or less before the beginning of the enrollment term, must list any physical limitations or medical restrictions for physical education activities, and must be signed by the examining physician.

You are required to provide this information to attend ORU. Please complete this form with your health care provider and return it either by mail, fax, or personal delivery to:

ORU Student Health Services

EMR Dorm, First Floor
7777 South Lewis Avenue
Tulsa, OK 74171
Office: (918) 495-6341 ● Fax: (918) 495-6274

General Information

Student ID Number: Z_____

Date of Birth: _____ ❑ Male ❑ Female

_____
Last Name First Name Middle Initial

_____
Present Address

_____
City State Zip Code Country

Home Telephone No.: _____

Cell Telephone No.: _____

Plan to Enter University: _____ / _____
Month / Year

Entering as: ❑ Fr ❑ So ❑ Jr ❑ Sr ❑ Grad

Student Status: ❑ Full-Time ❑ Part-Time

I plan to live: ❑ On Campus ❑ Off Campus

[For Returning Students]: Dates of Previous Enrollment: _____ to _____

I have previously been seen at ORU Student Health Services as a patient. ❑ Yes ❑ No

EMERGENCY CONTACT: Please provide the name, relation, and phone numbers of a family member or other person to be contacted on your behalf in an emergency:

Name	Relationship	Home or Cell Phone	Work or Cell Phone

AUTHORIZATION AND PERMISSION *To be signed by student*

[Attention parents/guardians: If your child will be under the age of 18, you must also sign the authorization.]

I authorize Oral Roberts University at its discretion, acting by its medical staff or by one of its officers, to make provision in my behalf, with any reputable physician, hospital, or clinic for medical care and treatment, including surgery, anesthesia, diagnostic, and therapeutic procedures as may be deemed necessary for said treatment.

I hereby give my permission to any physician, medical clinic, or hospital to release any information to Student Health Services at Oral Roberts University.

_____ _____
Printed Name of Student Signature of Student

_____ _____
Signature of Parent/Guardian Date

TO BE COMPLETED BY STUDENT

Name: _____ Z#: _____

Student's Past and Present Medical History

1. Are you involved in any regular exercise program? ❑ Yes (How long each week?) _____ ❑ No
2. Are the following medical conditions included in your family history? (indicate relation) ❑ Diabetes _____
   ❑ Heart Disease _____ ❑ High Blood Pressure _____ ❑ Cancer _____ ❑ Other _____
3. Are you currently under a doctor's care? ❑ Yes ❑ No (If yes, please explain and give physician's name and address below.

   _____
4. List prescribed medications you are taking: _____

   _____
5. List over-the-counter medications (including vitamins) you take without a prescription: _____

   _____
6. List any physical challenges: _____
7. Please circle "Yes" or "No" if your medical history includes any of the following:

Yes	No	1	Head injury or concussion	Yes	No	28	Liver problems, hepatitis, cirrhosis
Yes	No	2	A "stroke"	Yes	No	29	Diabetes
Yes	No	3	Epilepsy (seizures, convulsions), fainting	Yes	No	30	Sickle cell disease or trait
Yes	No	4	Treatment for emotional or nervous problems	Yes	No	31	Malaria, other tropical diseases
Yes	No	5	Frequent trouble sleeping	Yes	No	32	Enlarged lymph gland
Yes	No	6	Attempted suicide	Yes	No	33	Cancer
Yes	No	7	Frequent or severe headaches, migraine	Yes	No	34	Cysts or tumors
Yes	No	8	Meningitis	Yes	No	35	Kidney or bladder problem
Yes	No	9	Glasses or contacts	Yes	No	36	Rectal bleeding, fissure, abscess,
Yes	No	10	Eye problems, glaucoma, cataracts, etc.	Yes	No	37	Colitis or chronic constipation
Yes	No	11	Hearing loss, freq. ear infection, ringing in ears	Yes	No	38	High blood pressure
Yes	No	12	Mouth or throat problems, tonsillitis	Yes	No	39	Venereal disease
Yes	No	13	Nose problems, hay fever	Yes	No	40	Alcoholism
Yes	No	14	Thyroid	Yes	No	41	Hernia or hernia repair
Yes	No	15	Chest pain, chronic cough, coughing up	Yes	No	42	Weight problems
Yes	No	16	Difficulty breathing, shortness of breath	Yes	No	43	Anemia or blood disorder
Yes	No	17	Tightness in chest	Yes	No	44	Back, neck, or spine problems, disc disease
Yes	No	18	Asthma, emphysema, pneumonia	Yes	No	45	Broken Bones
Yes	No	19	Tuberculosis (TB, collapsed lung)	Yes	No	46	Need to wear back brace or support
Yes	No	20	Heart problems, night sweats	Yes	No	47	Joint problems, arthritis, bursitis
Yes	No	21	Breast problems, lump in breast	Yes	No	48	Joint injuries, knee, shoulder, etc.
Yes	No	22	Chronic recurring infections, boils, cold	Yes	No	49	Ankle or leg swelling, cramps, varicose
Yes	No	23	Skin problems or rashes	Yes	No	50	Foot problems
Yes	No	24	Chronic indigestion, diarrhea, food	Yes	No	51	Childhood diseases (measles, mumps, rubella)
Yes	No	25	Abdominal pain	Yes	No	52	History of drug abuse
Yes	No	26	Hiatal hernia, gallbladder trouble	Yes	No	53	Other
Yes	No	27	Ulcer, stomach problems	Yes	No	54	Other

Please explain any "yes" answer above and give approximate dates.

#____ Date_____ _____
#____ Date_____ _____
#____ Date_____ _____
#____ Date_____ _____
#____ Date_____ _____
#____ Date_____ _____

8. Please list any known allergies for which you might require medication or preventative measures (include food, dust, drugs, soaps, pollens, detergents, chemicals): _____

   _____

TO BE COMPLETED BY STUDENT

To the Student

Please fill out the following page of this Medical Assessment Form regarding immunizations, **review the information with your physician, and obtain immunizations if necessary.** <u>All responses must be in English</u>. You may attach additional immunization information from other schools or physicians' offices.

Name: _____ Z#: _____

IMMUNIZATIONS

Oral Roberts University adheres to all state laws and public health policies regarding immunizations. All full-time and/or residential students are to be immunized against **diphtheria (DTP), tetanus (Td), measles ,mumps, rubella (MMR1, MMR2), hepatitis B (HepB1, 2, 3),** and **meningitis (MPSV4 or MCV4)**, and provide results of a **Tuberculosis Test(TB) (**or chest x-ray, if needed). All part-time students are required to submit documentation of a current TB Test, the MMR Series, HepB3,Series, and Meningococcal vaccination. *All responses must be in English.*

Documentation

You **MUST** attach a photocopy of your original vaccination record which includes the vaccination **date** and **official stamp or signature** of the administering Healthcare Provider or Clinic **OR** have the physician performing your Medical Assessment sign below **[Box 7]** to verify your immunization records.

1 DTP Series (Diphtheria, Tetanus, Pertussis)

(1) DTaP/DTP/DT/Td _____ / _____ / _____ (Month / Day / Year)

(2) DTaP/DTP/DT/Td _____ / _____ / _____ (Month / Day / Year)

(3) DTaP/DTP/DT/Td _____ / _____ / _____ (Month / Day / Year)

(4) DTaP/DTP/DT/Td _____ / _____ / _____ (Month / Day / Year)

(5) DT/Td _____ / _____ / _____ (Month / Day / Year)

* **Last Tetanus/Diphtheria (Td)** (Within past 10 years)

* _____ / _____ / _____ (Month / Day / Year)

2 Polio Immunization

[Inactivated Polio Virus (IPV) or Oral Polio Virus (OPV)]

(1) IPV/OPV_____ / _____ / _____ (Month / Day / Year)

(2) IPV/OPV_____ / _____ / _____ (Month / Day / Year)

(3) IPV/OPV_____ / _____ / _____ (Month / Day / Year)

(4) IPV/OPV_____ / _____ / _____ (Month / Day / Year)

* **Primary Series Completed?**: ❑ Yes ❑ No

(5) IPV/OPV_____ / _____ /_____ (Month / Day / Year)

3 Tuberculosis Test (PPD-Mantoux)

(Taken in the past 12 months regardless of BCG vaccination)

Administered on: _____ /____ /_____ by _____ (Month / Day / Year)

PPD read: _____ /_____ /_____ by _____ (Month / Day / Year)

PPD Test Results: _____mm_____

X-Ray Report Attached? ❑ Yes ❑ No

Have you had a BCG Vaccination? ❑ Yes ❑ No

[If yes, please give the date]: _____/_____/_____ (Month / Day / Year)

NOTE: For the public health of our student body, It is RECOMMENDED that you supply the following immunization information:

Have you had Chicken Pox Disease? ❑ Yes ❑ No

Have you had the **Varicella Vaccination:**

#1 _____ / _____ / _____ (Month / Day / Year) **#2** _____ / _____ / _____ (Month / Day / Year)

4 Measles, Mumps, Rubella (MMR)

(First dose after age 12 months; 2 doses required.)

MMR #1 _____ / _____ / _____ (Month / Day / Year)

MMR #2 _____ / _____ / _____ (Month / Day / Year)

5 Hepatitis B or A/B Vaccine (3 doses required)

[Not Required] **HepA1** _____ /_____/ _____ (Month / Day / Year)

[Not Required] **HepA2** _____ /_____/ _____ (Month / Day / Year)

REQUIRED:

Hep B1 _____ /_____/ _____ (Month / Day / Year)

Hep B2 _____ /_____ /_____ (1 mo. after HepB1) (Month / Day / Year)

Hep B3 _____ /____ /_____ (2 - 4 mos. After HepB2) (Month / Day / Year)

Or

2 doses of **Merck Recombivax 10 mcg:**

HepB1 _____ /_____/ _____ (Month / Day / Year)

HepB2 _____ /_____/ _____ (Month / Day / Year)

Dosage documented by Physician/Clinic

OPTIONAL

NOTE: Positive Blood Titer Test Results are accepted in lieu of documented vaccinations # 4 and #5. (*Lab documentation must be provided.*)

TEST	DATE	RESULTS
Measles	/ /	
Mumps	/ /	
Rubella	/ /	
Hepatitis B	/ /	

Diagnosis of Disease is not acceptable.

6 Meningococcal Vaccination (Specify type)

❑ Menomune (MPSV4) _____ /_____/ _____ (Month / Day / Year)

Or

❑ Menactra (MCV4) _____ /_____/ _____ (Month / Day / Year)

7

_____

Physician's Signature and/or Stamp

_____

Date

REQUIRED IMMUNIZATIONS

Name: _____ Z#: _____

Student's Physical Examination *(To be completed by physician)*

Ht _____ Wt _____ BP _____/_____ Pulse _____ Respiration _____ Vision--R: 20/_____ L: 20/_____

Glasses ❑ Contact Lenses ❑

Please check N (normal) or AB (abnormal) and explain abnormalities.

	N	AB	Abnormalities
1. Head—scalp			
2. Eyes—fundi			
3. Ears, nose, throat, tonsils			
4. Teeth, gums, tongue			
5. Neck—thyroid, carotid, lymph nodes			
6. Lungs			
7. Heart			
8. Breast—lumps, masses, axillae			
9. Abdomen—tender, tumors, masses, hernia			
10. Groin—hernia or repair			
11. Back—surgery, scoliosis, lordosis			
12. Extremities—feet, varicosities, edema, pigmentation, pulses			
13. Skin—complexion, rash, scars			
14. Neuro—reflexes			
15. Joints—hips, knees, ankles, toes, wrist, shoulder			

ALLERGIES: Which of the following applies to this patient? (List specific substance):

❑ Allergic to antibiotics _____ ❑ Takes allergy shots _____
❑ Allergic to other medications _____ ❑ Takes allergy medication _____
❑ Allergic to pollens _____ ❑ Currently takes other medications _____
❑ Allergic to foods _____ ❑ Allergic to other substances _____

Are there any recommendations for special dietary requirements? ❑ Yes ❑ No [Specify] _____
Are there any recommendations for special housing considerations? ❑ Yes ❑ No [Specify] _____
Is this individual under care for a chronic condition or serious illness? ❑ Yes ❑ No *If so, please list recommendations for care of this individual:* _____
Please attach physician letter if more space is needed. **Is a letter from the physican attached?** ❑ Yes ❑ No

To the Physician

Oral Roberts University believes in developing the whole person: body, mind, and spirit. The health, physical education, and recreation (HPER) department strives to develop a personal fitness program for every individual according to his or her physical ability. Requirements normally include a 2-mile run or walk, a 5 ½ mile cycle, or an 800-meter swim each semester—each done within a specified timeframe according to age and sex. Your recommendations would greatly assist us in performing this task.

Physician's Recommendations for Exercise *(To be completed by physician)*

❑ **NO Restrictions for an exercise program.** ❑ **Restriction recommendation as follows:**

Due to the nature of this student's injury, illness, or physical limitation (specify) _____,
I advise that physical education activities be restricted:
❑ Less than 6 weeks _____ ❑ More than 6 weeks _____ ❑ Permanently

The following activities ARE recommended for this individual:

❑ walking	❑ cycling	❑ weight training/calisthenics
❑ jogging	❑ stationary cycling	❑ arm crank exercises
❑ swimming	❑ sports activities	❑ supervised treadmill walking

This form MUST be signed (or stamped) by Health Care provider in order to be valid.

HEALTH CARE PROVIDER: Date: _____

Name: _____ Phone: _____

Address: _____ Fax: _____

City/State/Zip: _____

_____
Physician's Signature

TO BE COMPLETED BY PHYSICIAN