

Fontbonne University Resident Medical Information

Welcome to Fontbonne University! Please read the following information very carefully. This page will explain all medical requirements for resident students. On page 2 you will find the Medical History Form and Permission to Treat Minors.

Medical Records: The Campus Nurse office strives to maintain strict confidentiality of all student medical records. Information will only be released if approved by the student. Fontbonne University requires all first time resident students complete the **Medical History Form and show proof of required immunizations. If the student is under the age of 18, obtain parent permission to treat in case of emergency.** See page 2.

Immunization Requirements: As part of the occupancy requirements, first time applicants (resident domestic and international students) must show proof of receiving the following Immunizations:

- **Tuberculin Skin Test (PPD):** must be no older than six (6) months prior to moving into university housing. International students must obtain the TB skin test in America, not their home country, **TB skin tests received outside the US will not be accepted.**
- **Meningococcal vaccine (Meningitis):** can receive at home by July 10 for fall semester, November 10 for spring semester, and April 10 for summer session.
- **Mumps (MMR):** can receive at home by July 10 for fall semester, November 10 for spring semester, and April 10 for summer session.

Recommended immunizations include, however are not required: Hepatitis A and B, Tetanus/Diphtheria (TD) and Varicella (Chicken Pox).

Positive Tuberculosis skin tests: If the Campus Nurse is notified that a resident student has a positive TB skin test, additional medical attention is required. This additional medical attention is necessary and requires a chest x-ray. It is the resident student's responsibility to provide the university with written medical documentation that this x-ray and follow up medical attention has been received.

Immunization documentation along with the Medical Health Form and Parental Permission to Treat a Minor, is due in the office of the Campus Nurse (located in the Student Affairs Office) by August 1 for fall semester; and by January 1 for the spring semester, April 1 for summer semester. You may not be allowed to move in if the Campus Nurse does not have your records prior to opening day. Any student failing to complete these requirements may jeopardize their housing assignment. Failure to submit documentation of the required vaccination does not alleviate your responsibility under any contractual relationship with the Residential Life Office.

All Resident Students are required to provide an emergency contact phone number, and attach a copy of their Immunization documentation to the Medical History Form.

Your information can be sent to the campus nurse by:

Mail:	OR	Fax:
Carla Hagan, RN/Campus Nurse Fontbonne University 6800 Wydown Blvd. St. Louis, MO 63105		Carla Hagan, RN/Campus Nurse (314) 889-4565

To preserve confidentiality, do not email documents.

If you have any questions or concerns, please contact the nurse at (314)-889-4784.

Fontbonne University Medical History Form, Health Insurance Verification and Permission to Treat Minors

*(This is a **confidential** record of your medical history. The personal medical information contained here will not be released to any person except when you have authorized the Campus Nurse to release health information.)*

Name - Last, First: _____ **Student ID:** _____ **Date of Birth:** _____

Medical History: Do you have a present or past history of: check all that apply)

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Constipation	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions/siezure	<input type="checkbox"/> Heart problem	<input type="checkbox"/> Organ transplant
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Counseling/Therapy	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> Hepatitis/Jaundice	<input type="checkbox"/> Relationship problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Back problems	<input type="checkbox"/> Disability	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Rubella (3-day measles)
<input type="checkbox"/> Birth defects	<input type="checkbox"/> Drug use	<input type="checkbox"/> HIV disease	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Ear infections	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> Blood transfusion	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Intestinal problems	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Breast conditions	<input type="checkbox"/> Eye disease/disorder	<input type="checkbox"/> Irritable bowel disease	<input type="checkbox"/> Sinus problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fainting spells	<input type="checkbox"/> Joint disease or injury	<input type="checkbox"/> Skin problems (Chronic)
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Foreign travel	<input type="checkbox"/> kidney disease	<input type="checkbox"/> Sleep problems
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Gallbladder disease	<input type="checkbox"/> kidney stones	<input type="checkbox"/> Spleen problems
<input type="checkbox"/> Chronic cough	<input type="checkbox"/> Gastritis/indigestion/reflux	<input type="checkbox"/> Measles (Rubeola)	<input type="checkbox"/> Sprains/dislocations
<input type="checkbox"/> Chronic diarrhea	<input type="checkbox"/> Gynecological (GYN) problems	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Strep throat
<input type="checkbox"/> Crone's disease	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Menstrual problems	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Colitis	<input type="checkbox"/> Headaches (Recurrent)	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Concussion	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Mononucleosis (Mono)	<input type="checkbox"/> Ulcer
<input type="checkbox"/> I have none of the above			<input type="checkbox"/> Urinary Tract Infection

Immunization Documentation Attached

EMERGENCY CONTACT/PHONE NUMBER: _____

BRIEF EXPLANATION OF ANY CONDITIONS MARKED ABOVE:

DO YOU HAVE ANY HEALTH CONCERNS? Please list: _____

MEDICATIONS (list all currently taking):	MEDICATION/DRUG ALLERGIES and reactions
_____	_____
_____	_____

HOSPITALIZATIONS/SURGERIES:	ALLERGIES/Reactions: (latex, tape, foods, others)
_____	_____
_____	_____

Permission to Treat Minors: FOR ALL STUDENTS UNDER 18 YEARS OF AGE - I authorize the Fontbonne Campus Nurse to administer medical services, immunizations and other therapeutic procedures as deemed necessary by duly Missouri medical licensed personnel.

I give permission for such procedures as deemed necessary for my son/daughter/ward.

Signature	Relationship	Date
_____	_____	_____

Student Signature	Date
_____	_____