## zelpha mckinnon wellness center | Kettering university 1700 university avenue | flint, mi 48504 810.762.9650 – office | 810.762.9929 – fax | wellness@kettering.edu

# ADMISSION HEALTH RECORD

**Deadline for submitting the Admission Health Record Form**

Students accepted after the term deadline listed below have 30 days from date of acceptance to complete this form.

|  |  |  |  |
| --- | --- | --- | --- |
| **Summer Entrants** | **Fall Entrants** | **Winter Entrants** | **Spring Entrants** |
| June 1 | September 1 | December 1 | March 1 |

Instructions – Read prior to completing this form

1. All students are required to complete this form.
2. Part III Immunizations – Provide proof of immunization by submitting a copy of your immunization record from your physician, local health department, former high school or university, immigration paperwork, or other official immunization record. Any paperwork must list all immunizations in English.
3. Part IV Tuberculosis Self-Screening – Answer all questions. If you answer Yes to any questions, you will be required to submit a PPD skin test prior to registering for class.
4. Part V Emergency Contact and Signatures - Provide current emergency contact information. This form must be sent in with signatures to complete your health file.
5. Health Insurance - ALL STUDENTS are required to have health insurance and will be billed for student health insurance on their student account. Visit the Kettering University Wellness Center website [www.kettering.edu/wellness-center](http://www.kettering.edu/wellness-center) for information on deadlines and the verification process to request a waiver. F-1 visa holders are required to enroll into the university student health insurance policy (currently administered by Consolidated Health Plans).
6. Penalties – Students who fail to submit the completed Admission Health Record, including proof of immunizations and fail to rectify deficiencies within 30 days after the start of classes will be barred from class registration for subsequent terms until compliant.
7. Documents to return (**Parts III, IV, and V**) – Mail to Kettering University Wellness Center, 1700 University Avenue, Flint, MI 48504. Fax to 810.762.9929. OR email to [wellness@kettering.edu](mailto:wellness@kettering.edu).
8. Confirmation – Your Kettering email address will be used to communicate any information.

**Part I: Student and Academic Information**

|  |  |
| --- | --- |
| Student ID (9 digits): |  |
| Kettering Email Address: |  |
| Last Name: |  |
| First Name: |  |
| Permanent Address |  |
| Date of Birth (mm/dd/yyyy) |  |
| Sex at birth |  |
| Gender identity |  |
|  |  |

|  |  |
| --- | --- |
| Citizenship | \_\_\_US Citizen  \_\_\_Permanent Resident of US  \_\_\_Non-US/Non Permanent Resident |
| First Term attending and year of Enrollment: | Summer 20\_\_ Fall 20\_\_ Winter 20\_\_ Spring 20\_\_ |
| Indicate your academic program: | \_\_Undergraduate  \_\_Graduate |

Student Information Section – Completed by Student:

|  |
| --- |
| Last Name First Name MI Date of Birth (mm/dd/yyyy)  Sex at birth/Gender Identity Kettering Email Address Student ID# |

**Part II: Health History**

|  |  |
| --- | --- |
|  |  |

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|  |
| **PERSONAL HEALTH HISTORY** | |
|  | |
| List any medical conditions that any doctor has diagnosed | |
|  | |
|  | |
|  | |

|  |  |  |
| --- | --- | --- |
| List prescribed drugs and over-the-counter drugs (vitamins, inhalers, etc.) | | |
| Name the Drug | Strength | Frequency Taken |
|  |  |  |
|  |  |  |
| Allergies to medications | | |
| Name the Drug | Reaction You Had | |
|  |  | |
|  |  | |

**Part III: Immunizations**

Provide documentation showing all immunizations received. All documents must be physician signed and dated. Must be completed by a healthcare professional, in its entirety, in English, prior to Orientation.

Strongly recommended:

* Measles, Mumps, Rubella
* Meningitis
* Tetanus, Diphtheria
* Hepatitis A
* Hepatitis B
* Varicella (Chicken Pox)
* Human Papilloma Virus
* Influenza (seasonal)

Student Information Section – Completed by Student:

|  |
| --- |
| Last Name First Name MI Date of Birth (mm/dd/yyyy)  Sex at birth/Gender Identity Kettering Email Address Student ID# |

**Part IV: Tuberculosis Self-Screening (completed by student)**

PAST HISTORY:

|  |  |
| --- | --- |
| 1. Have you lived in any of the following countries for six months or more? Afghanistan, Bangladesh, Bolivia, Brazil, Cambodia, China, Congo, Ethiopia, India, Indonesia, Kazakhstan, Kenya, Mongolia, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Pakistan, Peru, Philippines, Republic of Korea, Russian Federation, South Africa, Tajikistan, Thailand, Uganda, United Republic of Tanzania, Vietnam, Zambia, Zimbabwe | YES NO |
|  |  |
| 2. Have you used intravenous drugs or had a history of alcoholism? | YES NO |
|  |  |
| 3. Do you have cancer, leukemia, kidney disease, diabetes, AIDS/HIV or take immunosuppressive medications such as prednisone? | YES NO |
|  |  |
| 4. Have you been in close contact with someone with tuberculosis? | YES NO |
|  |  |
| 5. Have you resided, worked or volunteered in a prison, homeless shelter, hospital, nursing home or other long term treatment facility? | YES NO |
|  |  |
| 6. Did you receive BCG? (Vaccination for Tuberculosis often given in foreign countries) | YES NO |

IMPORTANT: If you have answered "Yes" to any of the questions 1-5, you are required to have a PPD skin test before you can register for classes. This PPD test must be done within the 12 months prior to beginning your classes. You can obtain the PPD skin test from your local health care provider

NOTE TO LOCAL HEALTH PROFESSIONALS: Please record the size of the induration in millimeters - a result recorded as "Positive" or "Negative" will not be accepted. If there is no reaction, please record it as "0 mm". Students who have had BCG vaccine are still required to have a PPD skin test. Thank you for your assistance.

Date PPD Applied:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date PPD Read:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Size of Induration (in mm):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Read by (Health Professional's Name):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Professional's Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Information Section – Completed by Student:

|  |
| --- |
| Last Name First Name MI Date of Birth (mm/dd/yyyy)  Sex at birth/Gender Identity Kettering Email Address Student ID# |

**Part V: Emergency Contact and Signatures**

|  |  |  |
| --- | --- | --- |
| EMERGENCY CONTACT | | |
| Name | Relationship | Contact Number |
|  |  |  |
|  |  |  |

**Confidentiality**

All protected health information is confidential. Disclosure is not available to anyone without your informed written consent. This includes parents, spouses, and college officials. A Release of Authorization is available in the Wellness Center if you would like others to have access to your information.

**Student Signature (Required)**

Please sign and date below. By signing you are certifying that all information supplied is correct to the best of your knowledge.

I authorize and consent to medical, counseling and other procedures and treatment by the nurse, counselor and other staff at the Zelpha McKinnon Wellness Center. No guarantees or promises have been made concerning the outcome of any procedures or treatment. I understand that I have the right to make decisions concerning my health care, including my right to refuse medical or counseling services.

Signature Date

**Parent/Guardian Waiver**

## To be signed in ink by parent or guardian for all applicants under 18 years of age.

## I hereby give my permission for such necessary and emergency care to be given to my son/daughter at an approved medical facility, including the Wellness Center.

Signature Date