

**PERSONAL INFORMATION (required)**

Student ID# _____ Semester Arriving _____ Date of Birth ____/____/____ Age _____
Name: *First* _____ *MI* _____ *Last* _____ M _____ F _____
Home Address _____
City: _____ State: _____
SEU Dorm/Room # _____ Cell Number _____
Are you a U.S. or Canadian Citizen by birth? Y _____ N _____ If yes, do you live outside the U. S. or Canada? Y _____ N _____

EMERGENCY CONTACT (required for contact in the event of hospitalization or EMS transport)

Name _____ Relationship _____
Address: _____ City: _____ State: _____
Wk. Ph# () _____ Hm. Ph# () _____ Cell Ph# () _____

MEDICAL INSURANCE (optional but recommended)

- ☐ I already have medical insurance with: _____ (please attach a copy of insurance card to form).
☐ I do not have medical insurance.

PERSONAL HEALTH HISTORY

List all allergies to foods, medications, or other common substances: _____

List all medication taken on a regular basis, including over-the-counter medication:

Medication Name	Dosage	When Taken (daily, weekly, monthly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any hospital stays you have had, including date and reason for stay:

Do you have or have you ever had any of the following:

CONDITION	DATE of illness or onset of condition	CONDITION	DATE of illness or onset of condition	CONDITION	DATE of illness or onset of condition
Anxiety/ Depression		Heart disease/disorder		Pregnancy	
Asthma		High/low blood pressure		Rheumatic Fever	
Bones/joints disorder		Kidney disease/disorder		Sickle cell disease	
Bladder problems		Liver disease/disorder/Hepatitis		Skin disease/disorder	
Chronic back disorder		Migraine headaches		Spine disease/disorder	
Chronic diarrhea/constipation		Menstrual difficulties		Stomach/intestinal trouble	
Diabetes		Mononucleosis		Tuberculosis	
Ear disease/hearing problems		Muscular disease/disorder		Vertigo/dizziness	
Epilepsy/ Seizures		Physical limitations			
Eye disease/disorder		Polio			
Hay fever/seasonal allergies					

List illnesses or conditions, not listed above, for which you are now being treated (attach extra sheet if needed):

**IMMUNIZATION RECORD (required)**

Last Name _____ MI _____ First Name _____ Student ID _____

MMR**REQUIRED for All Applicants born after December 1956**

Applicant must show documentation of vaccination to Measles, Mumps, and Rubella (German measles).

Acceptable forms of documentation include the following. **Choose one option below:**

- | | |
|---|--|
| ☐ Pediatric Physician Shot Record attached | ☐ Laboratory evidence of immune titer attached (copy of lab result) |
| ☐ Health Department Shot Record attached | ☐ Doctor's signature _____ |
| ☐ School Health Record attached | indicating you have been properly vaccinated against MMR. |

HEPATITIS & MENINGITIS**RECOMMENDED for All Applicants**

SEU requires all traditional students attending the Lakeland campus to provide documentation of having received vaccinations against Meningococcal Meningitis and Hepatitis B OR to decline the vaccinations by signing this waiver below. Please indicate for each vaccination below that you have received or are declining the immunization. **Prior to declining the Hepatitis B or Meningitis vaccines, you are required to read the following information at:** <http://www.cdc.gov/vaccines/hcp/vis/vis-statements/hep-b.html>

<http://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html>

____ I have received (documentation attached), or ____ I have declined -the Meningococcal Meningitis vaccination.

____ I have received (documentation attached), or ____ I have declined -the Hepatitis B vaccination series.

Student's Signature (parent/guardian if under 18): _____ Date: _____

Submit OFFICIAL SHOT RECORDS from your doctor's office, Health Department, or High School transcript with this form.**CONSENT FOR MEDICAL TREATMENT AND RELEASE OF INFORMATION (required)**

I hereby authorize Southeastern University to employ diagnostic procedures and render any treatment deemed necessary for my health and well being. I grant permission for my transfer to an accredited hospital if deemed necessary by a licensed health care professional. In the event of an emergency, I authorize treatment of myself as deemed necessary by a licensed health care professional.

I also authorize SEU to release information concerning my medical condition to the following individuals:

____ Mother ____ Father ____ Guardian ____ Professors ____ Others _____

Student's Signature _____ Date _____

Witness _____ Date _____

For students under 18 years of age and unmarried OR those with a legal guardian, the parent or legal guardian must ALSO sign:

Signature _____ Relationship to Student _____

Address _____ Telephone _____

STUDENT AFFIRMATION (required)

I attest that the information on these medical health forms is true and accurate. I understand that these forms are necessary for admission to the university and that falsification of information may result in dismissal. SEU reserves the right to refuse enrollment to any applicant whose health record indicates the existence of a condition which may be harmful to the members of the university community.

Student's Signature (Parent/Guardian must sign if applicant is under 18) _____ Date _____

Please return forms directly to Health Services at

1000 Longfellow Boulevard Lakeland, FL 33801 or by
the private Health Services fax number: 863-667-5299

Health Services Contact Info:

Phone: 863-667-5205
Health Services Private Fax: 863-667-5299
E-mail: healthservices@seu.edu

TUBERCULOSIS SCREENING FORM**Print Name:** _____ **Student ID #** _____**Last First MI****SECTION A: Completed by Student****1. Have you ever been sick with tuberculosis? Circle: YES NO****2. Have you ever had a positive PPD, TB Quantiferon test, or T-SPOT? Circle: YES NO****3. Have you ever had close contact with persons known or suspected to have active TB disease? Circle: YES NO****4. Were you BORN in one of the countries listed below that have a high incidence of active TB disease? Circle: YES NO If YES, please circle the name of the country below.**

Afghanistan	Colombia	India	Namibia	Somalia
Albania	Comoros	Indonesia	Nauru	South Africa
Algeria	Congo	Iraq	Nepal	South Sudan
Angola	Cote d'Ivoire	Kazakhstan	Nicaragua	Sri Lanka
Anguilla	DPR of Korea	Kenya	Niger	Sudan
Argentina	Djibouti	Kiribati	Nigeria	Suriname
Armenia	Dominican Rep	Kuwait	Niue	Swaziland
Azerbaijan	Ecuador	Kyrgyzstan	N Marianna Isl	Tajikistan
Bangladesh	El Salvador	Lao (PDR)	Pakistan	Tanzania
Belarus	Equatorial Guinea	Latvia	Palau	Thailand
Belize	Eritrea	Lesotho	Panama	Timor-Leste
Benin	eSwatini	Liberia	Papua N Guinea	Togo
Bhutan	Ethiopia	Libya	Paraguay	Tunisia
Bolivia	Fiji	Lithuania	Peru	Turkmenistan
Bosnia-Herzeg.	French Polynesia	Madagascar	Philippines	Tuvalu
Botswana	Gabon	Malawi	Portugal	Uganda
Brazil	Gambia	Malaysia	Qatar	Ukraine
Brunei Daruss.	Georgia (nation)	Maldives	Rep of Korea	Uruguay
Bulgaria	Ghana	Mali	Rep of Moldova	Uzbekistan
Burkina Faso	Greenland	Marshall Islands	Romania	Vanuatu
Burundi	Guam	Mauritania	Russian Fed	Venezuela
Cabo Verde	Guatemala	Mexico	Rawanda	Viet Nam
Cambodia	Guinea	Micronesia	SaoTome Prin	Yemen
Cameroon	Guinea-Bissau	Mongolia	Senegal	Zambia
Cent. African Rep	Guyana	Morocco	Sierra Leone	Zimbabwe
Chad	Haiti	Mozambique	Singapore	
China	Honduras	Myanmar	Solomon Islands	

5. Have you had frequent or prolonged (more than 30 days) visits to one or more of the countries listed above? Circle: YES NO**If YES, list countries here:** _____**6. Have you been a resident, volunteer, or employee of a high-risk congregate setting (ex. hospital, jail, nursing home, homeless shelter)? Circle: YES NO****7. Have you had HIV, AIDS, diabetes, leukemia, lymphoma, a chronic immune disorder, or received treatment for drug/alcohol abuse? Circle: YES NO****8. Do you currently have a persistent cough (3 weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? Circle: YES NO****SEE BACK OF PAGE**

ONLY if the answer was YES to any of the questions on the previous page, or if you were BORN in one of the countries listed, a licensed health care provider must complete SECTION B below.

SECTION B: Completed by Healthcare Professional

If student answered YES to any of the above questions, proof of a PPD, QuantiFERON-TB Gold, or T-SPOT is required. If PPD results are greater than 10mm OR QuantiFERON TB-Gold or T-SPOT is positive, a chest x-ray is required. Testing and/or chest x-ray must be done within one calendar year prior to admittance to the University (unless student has a history of positive PPD). If student has a history of positive PPD, a chest x-ray is required. History of BCG vaccination does not prevent testing of a member of a high risk group.*

PPD: Date Placed _____ Date Read _____

Number of mm induration _____

QuantiFERON-TB Gold or T-SPOT: Result Date _____

Result (attach lab report) _____

Chest X-ray (if indicated):

Date of x-ray _____ Result _____

If negative chest x-ray but positive PPD, did student complete a course of INH (Isoniazid)? Circle: YES NO

If YES, when? Month & year treatment began: _____

Number of months treatment continued: _____

Current treatment recommendations:

Signature of Healthcare Provider: _____

Date: _____ Practice Phone #: _____

*greater than 5mm if patient has had recent close contact with a person with infectious TB, has had fibrotic changes on prior chest x-ray, is HIV positive, or is otherwise immunosuppressed

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