

Mental Health Care (Psychiatric or Psychological):

Please check all that apply

Eating Disorder (anorexia, bulimia) _____

Depression/Anxiety/BiPolar Disorder, etc. _____

Suicide Attempts _____

Alcohol/Drug Treatment: Dates of Treatment _____

Outpatient Care: Diagnosis, Dates of Treatment, Medications _____

Inpatient Care: Diagnosis, Dates of Treatment, Medications _____

Disabilities:

Have you ever had an accommodated disability? Yes No

If yes, what type? Medical Mental Health Learning

Other Medical Information:

Please note any other pertinent information that you feel would be essential to the Center for Health and Wellness to ensure that you receive complete care while at Capital.

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Student Signature

Date

Insurance Information:

Health Insurance Information: _____
Insurer Name Phone Number

Address: _____
Street City State ZIP

Policy Number: _____ Subscriber ID: _____

Group Number: _____

Issue Date: _____ Expires: _____

Health Information and Immunization Form

Please Return Form by July 1 to: **Student and Community Engagement Office**
Capital University
1 College and Main
Columbus, OH 43209-2394
Phone: 614-236-6901 Fax: 614-236-6290

Required Immunizations:

Tetanus, Diphtheria, Pertussis: within the last ten years

(mm) (dd) (yy)

Measles, Mumps, and Rubella: two immunizations

1.

(mm) (dd) (yy)

2.

(mm) (dd) (yy)

Polio: Completed primary series of polio immunizations

Yes No

Last Booster:
(if applicable)

(mm) (dd) (yy)

Tuberculosis Questionnaire Completed

Yes No

Health Care Provider (M.D., D.O., N.P.)

Signature: _____ Date: _____

Name: _____
Please Print

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Tuberculosis Screening Questionnaire

All Capital University students are required to provide information about overseas travel and possible exposure to tuberculosis (TB) prior to the start of classes. If you have been overseas, you should be tested for TB within 8-10 weeks after returning to the United States.

Last Name: _____ First Name: _____

Date Completed: _____

Have you ever had a positive TB test? Yes No

Have you lived or traveled to a country OTHER than those listed below? Yes No

If so, give name of country _____ Dates of travel _____

American Regions: Canada Jamaica St. Kitts & Nevis US Virgin Islands St. Lucia

European Regions: Belgium Denmark Finland Germany Greece Iceland Ireland Italy
Liechtenstein Malta UK Monaco Norway Netherlands San Marino Switzerland

Western Pacific Regions: American Samoa Australia New Zealand

Have you ever been vaccinated with BCG? Yes No

Have you had any of the following symptoms?
3 weeks of unexplained cough or bloody sputum? Yes No
Unexplained night sweats, weight loss, or fever? Yes No

Do you have any of the following risk factors to TB infection?
Cancer or long term immunosuppressive therapy or steroids? Yes No
Use of illegal drugs? Yes No
Close contact with an active TB patient? Yes No
HIV infection or AIDS? Yes No
Recent resident or employee of correctional facility,
nursing home, homeless shelter, or health care setting? Yes No

If you answered yes to any of the above questions, you will need to provide a record of a TB skin test administered in the U.S. to Capital's Center for Health and Wellness. Previous BCG vaccination does not exempt you from TB testing.

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Meningococcal and Hepatitis B Status Form

Required State of Ohio Form for all Capital University Students

It is required by the State of Ohio Revised Code Section 3701.133, (B), that you complete this form for our files. You are not required to have these immunizations to enter the university but you must list whether you've had them or not. The Center for Health and Wellness strongly recommends that college students receive these immunizations.

Name of Student: _____

Social Security Number or Student ID Number: _____ Date of Birth: _____

Meningococcal Vaccine received: Yes No

If yes, please give date: _____

Hepatitis B vaccine received: Yes No

If yes, please give dates:

1st Dose: _____

2nd Dose: _____

3rd Dose: _____

This form must be dated and signed by the student if they are 18 years old or older or by the parent or guardian if the student is under 18.

Signature: _____ Date: _____