Morris College

HEALTH PROFILE INFORMATION

This form must be completed by student and/or parent.

Please complete this Health Care Certificate and return it to the Health Services Center before July 1 for Fall semester admission or December 1 for Spring semester admission. Permission to register is dependent upon completion of this form. Please call 803-934-3256 if you have questions.

STUDENT INFORMATION

Student's Name _____ Entry Term (Semester/Year) _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Student Cell _____

Date of Birth _____ Social Security Number _____

Sex: ☐ Male ☐ Female

Do you plan to participate on an athletic team? ☐ Yes ☐ No If so, what sport? _____

Person to notify in case of medical emergency:

Name _____ Relationship _____

Address _____

Home Phone _____ Cell ___ Work _____

If the above number cannot be reached, notify _____ Relationship _____

Home Phone _____ Cell _____ Work _____

Person to notify in case of mental health emergency: ☐ Same as medical emergency contact ☐ I do not want to designate at this time

Name _____ Relationship _____

Address _____

Home Phone _____ Cell _____ Work _____

INSURANCE INFORMATION - Please include a copy of your insurance card (front and back).

In case of treatment as an outpatient at the hospital or should inpatient hospitalization be required, the bill for care will be sent directly to the student, parent, or legal guardian unless the name and policy number of insurance coverage is provided. If your son/daughter is covered by such a policy, **please fill in the following and attach a front and back copy of the card:**

Name of Insured _____ Social Security Number _____

Insurance Company _____ Group Number _____

ID Number _____ Phone _____

CONSENT FOR TREATMENT OF MINOR STUDENTS

Any person who has reached the age of 18 may, in the State of South Carolina, sign his or her own consent for treatment at a hospital or other medical care facility. This is also the case for consenting for counseling and other mental health services. If the student has not reached the age of 18, the following must be signed by the student's parent/guardian for the student to receive treatment.

I, _____ hereby give permission for **emergency medical treatment** for

_____ should it be necessary before s/he reaches the age of 18.

I, _____ hereby give permission for **mental health treatment** for

_____ should it be necessary before s/he reaches the age of 18.

HEALTH HISTORY

1. Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergies:
   ☐ Medicines _____ ☐ Pollens _____ ☐ Food _____ ☐ Stinging Insects _____
   ☐ Animals _____ Other: _____

2. If yes, are you receiving allergy shots? ☐ Yes ☐ No

   If yes, will the shots continue while attending college? ☐ Yes ☐ No

3. Give details and dates of all operations and/or hospitalizations (including tonsils and adenoids). ☐ None

   _____

   _____

4. Give details of accidents including dislocations, fractures, and any injury with loss of consciousness. ☐ None

   _____

   _____

5. Are you taking any prescription and/or non-prescription medications or supplements (herbal and nutritional)? ☐ Yes ☐ No
   If yes, please list all prescription and non-prescription medications (name, dosage, and frequency): _____

   _____

6. When was your last dental examination? _____
   When was your last eye examination? _____

7. Do you wear glasses/contact lenses? ☐ Yes ☐ No

8. Have you been under the care of a medical specialist during the past year? ☐ Yes ☐ No

   If yes, indicate the reason: _____

   Name, address, and phone of specialist _____

   _____

   Dates of Treatment _____

9. Have you been under the care of a mental health specialist (counselor, psychologist, social worker, psychiatrist) during the past year? ☐ Yes ☐ No If yes, indicate the reason: _____

   Name, address, and phone of specialist _____

   _____

   Dates of Treatment _____

10. Give age or ages at which you have had any of the following:

- ☐ Anxiety Disorder _____
- ☐ Asthma _____
- ☐ Bipolar Disorder _____
- ☐ Cancer _____
- ☐ Chicken Pox _____
- ☐ Colitis _____
- ☐ Depression _____
- ☐ Diabetes _____
- ☐ Digestive Tract Problem _____
- ☐ Eating Disorder _____
- ☐ Epilepsy/Seizures _____
- ☐ German Measles _____
- ☐ Hay Fever _____
- ☐ Hearing Loss _____
- ☐ Heart Disease/Murmur/ Palpitation _____
- ☐ Hepatitis A, B, or C _____
- ☐ Infectious Mononucleosis _____
- ☐ Malaria _____
- ☐ Measles _____
- ☐ Mumps _____
- ☐ Pneumonia _____
- ☐ Post Traumatic Stress Disorder _____
- ☐ Rheumatic Fever _____
- ☐ Rheumatism _____
- ☐ Sickle Cell Trait/Disease _____
- ☐ Skin Disorders _____
- ☐ Strep Throat _____
- ☐ Stomach Ulcer _____
- ☐ Substance Abuse _____
  - ☐ Alcohol _____
  - ☐ Tobacco _____
  - ☐ Other Drugs _____
- ☐ Suicide Attempt _____
- ☐ Thyroid Disease _____
- ☐ Tuberculosis _____
- ☐ Urinary Tract Infection _____

Other diseases (name) _____

11. Any family history of medically unexplained or cardiac cause of death under age 50? ☐ Yes ☐ No
    If yes, please explain: _____

12. Do you have pain or other trouble with your back, legs, feet, hands, or joints? ☐ Yes ☐ No
    If yes, please explain: _____

13. Has your weight changed in the past six months? ☐ Yes ☐ No
    Gain or loss? _____How much? _____Why? _____

    Do you have any concerns about food? ☐ Yes ☐ No
    If yes, please explain: _____

CERTIFICATION OF INFORMATION

I certify that the information provided is accurate to the best of my knowledge.

Student Signature _____Date _____

Parent Signature _____Date _____

Please mail, email, or return completed Health Profile with completed Physical Examination and Immunization Record forms to the address listed below before July 1 for the Fall admission or December 1 for Spring admission. Permission to register is dependent upon completion of this form. Please call if you have questions.

MORRIS COLLEGE
Attention: HEALTH SERVICES CENTER
100 West College Street
SUMTER, SC 29150
Phone: (803) 934-3256

Email: Mchealth@morris.edu

Morris College

PHYSICAL EXAM & IMMUNIZATION RECORD

Please give this form to your physician, nurse practitioner or physician's assistant. This form will also serve as a pre-participation Sports Physical for incoming college athletes.

TO THE EXAMINING PROVIDER: Please complete the Physical Exam and Immunization Record. This information is necessary for the College to best serve the student.

Please complete and return via email or mail to:

Morris College, Attention: Health Services Center, 100 West College Street, Sumter, SC 29150. Should you have any questions, contact us at 803-934-3256.

Student's Name _____ DOB_____ ☐ Male ☐ Female ☐ Transgender
Last *First* *Middle*

Measurements:

Temp _____ Pulse_____ Resp _____ BP_____ Height _____ inches Weight_____lbs BMI _____

Visual Acuity: Uncorrected [ ] Right 20/ _____ Left 20/ _____ Corrected [ ] Right 20/ _____ Left 20/ _____

Are there any abnormalities of the following systems? Please describe fully. Use additional sheet if needed.

	Normal	Abnormal	Not Examined	
General Appearance: Marfan stigmata, LOC, nutrition, development, mobility, affect, speech, hygiene				
Skin: rash, HSV, lesions suggestive of MRSA, color, tinea corporis, acne				
Head: shape, size, symmetry, scalp, TMJ, lesions, hair				
Eyes: Lids, conjunctiva, sclera				
Extraocular muscles				
Visual fields				
Pupils: size, reaction to light and accommodation				
Fundi				
Ears: pinna, canals, TMs, hearing				
Nose: patency, nares, sinuses, nasal mucosa, septum, turbinates				
Mouth: lips, gums, teeth, mucosa, palate, tongue				
Throat: pharynx, tonsils, uvula				
Neck: ROM, symmetry, palpation, thyroid, lymph nodes				
Breasts: size, symmetry, skin, nipples, palpation, nodes				
Chest/Lung: excursion, palpation, percussion, auscultation				
Cardiac: PMI, palpation, rate, rhythm, S1, S2, murmurs (standing, supine, +/- Valsalva), gallops, bruits, extra sounds				
Abdomen: appearance, bowel sounds, bruits, percussion, palpation, liver, spleen, flank, suprapubic, hernia				
Anorectal: perianal, digital rectal, stool guaiac				
Female Genitalia: Internal: vaginal mucosal, cervix				
Bimanual: vagina, cervix, uterus, adnexa				
Male Genitalia: penis, scrotum, testes, hernia				

Lymph Nodes: cervical, subclavian, axillary, inguinal, other				
Musculoskeletal: Back/Spine: ROM, palpation				
Upper Extremity: ROM, strength, palpation of shoulder/arm/elbow/ forearm/wrist/hand/fingers				
Lower Extremity: ROM, strength, palpation of hip/thigh/knee/leg/ankle/ foot/toes				
Functional: Duck-walk, single leg hop				
Peripheral Vascular: Upper Extremity: pulses, appearance, temp				
Lower Extremity: pulses, appearance, temp, simultaneous femoral and radial pulses				
Neurologic: cranial nerves, motor, sensory, cerebellar, reflexes, gait, mental status				

ASSESSMENT:

ATHLETES ONLY: Sickle Cell Trait* ☐ Yes ☐ No (attach documentation)

**The NAiA mandates that all student athletes have knowledge of their sickle cell trait status before any participation in intercollegiate sports.*

Based on this examination, I approve the student's participation in:

☐ Any intercollegiate sports for one year ☐ Yes ☐ No ☐ Limited

☐ Any physical education activity class with no restrictions

☐ An adapted physical education program to exclude the following activities: _____

☐ No physical education activity classes for the following reason(s): _____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

Have you ever had a positive TB skin test? ☐ Yes ☐ No

Have you ever been vaccinated with BCG? ☐ Yes ☐ No

Have you ever had close contact with persons known or suspected to have active TB disease? ☐ Yes ☐ No

Were you born or have lived outside of the U.S.? ☐ Yes ☐ No If yes, what country: _____

If the answer to any of these questions is yes, a Tuberculin Skin Test is required.

Tuberculin Skin Test Date given: ___/___/___ Date read: ___/___/___

Result:_____ (record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): ☐ Positive ☐ Negative

Interferon Gamma Release Assay (IGRA) Date Obtained: ___/___/___

(specify method) ☐ QFT-GIT ☐ T-Spot ☐ other

Result: ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-Spot only)

Chest X-ray (required if TST or IGRA or T-Spot is positive) Result: ☐ Normal ☐ Abnormal Date of chest x-ray: ___/___/___

IMMUNIZATION RECORD (All dates must have month, day, and year) *Required for entrance.

As of July 1989, all students born after January 1, 1957, registering for the first time at public or private colleges in South Carolina must present evidence of immunity against the vaccine-preventable diseases. If no proof of immunization, certification of medical exemption, or statement of religious **exemption is presented, the student will not be permitted to register for courses**

REQUIRED IMMUNIZATIONS:

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

Dose 1 given at age 12 months or later #1 _/_/_
Dose 2 given at least 28 days after first dose #2 ___/ /_

B. MENINGOCOCCAL QUADRIVALENT

(South Carolina Law: Students must have had one menactra (conjugate) after age of 16.) *Not required for students over the age of 22.* (A, C, Y, W-135) One or 2 doses for all college students; revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1___/___/__
   b. Dose #2 ___/___/__
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date: ___/___/__

C. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of disease: ☐ Yes ☐ No or Birth in U.S. before 1980: ☐ Yes ☐ No
2. Varicella antibody: ___/___/___ Result: ☐ Reactive ☐ Non-reactive
3. Immunization: Dose #1 ___/___/__
   Dose #2 given at least 12 weeks after first dose ages 1–12 years and at least 4 weeks after first dose if age 13 years or older ___/___/___

D. TETANUS, DIPHTHERIA, PERTUSSIS

(South Carolina Law: Students must have had a TDAP within the last 10 years)

1. Primary series completed? ☐ Yes ☐ No
   Date of last dose in series: ___/___/____
2. Date of most recent booster dose: ___/___/____
   Type of booster: ☐ Td ☐ Tdap *Tdap booster recommended for ages 11-64 unless contraindicated.*

E. HEPATITIS B

(All college athletes and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

4. Immunization (Hepatitis B)

a. Dose #1 ___/___/___ ___Adult formulation or ___Child formulation
b. Dose #2 ___/___/___ ___Adult formulation or ___Child formulation
c. Dose #3 ___/___/___ ___Adult formulation or ___Child formulation

5. Immunization (Combined Hepatitis A and B vaccine)

a. Dose #1 ___/___/__
b. Dose #2 ___/___/__
c. Dose #3 ___/___/__

6. Hepatitis B surface antibody Date: ___/___/___ Result: ☐ Reactive ☐ Non-reactive

STRONGLY RECOMMENDED IMMUNIZATIONS (Not required):

F. Polio

Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.

7. OPV alone (oral Sabin three doses):
   a. Dose #1 ___/___/__
   b. Dose #2 ___/___/__
   c. Dose #3 ___/___/__

8. IPV/OPV sequential:
   IPV #1___/___/_
   IPV #2__/__/ _
   OPV #3__/__/ _
   OPV #4___/___/_
9. IPV alone (injected Salk four doses):
   a. Dose #1 ___/___/__
   b. Dose #2 ___/___/__
   c. Dose #3 ___/___/__
   d. Dose #4 ___/___/__

COVID VACCINATION

Please provide a copy of your COVID immunization documentation to the health service team if you are fully vaccinated for our records. At this time, COVID vaccination is **highly recommended but not required** for attendance at Morris College.

G. INFLUENZA

☐ Trivalent ☐ Quadrivalent ☐ Recombinant ☐ Live attenuated influenza vaccine. Date of last dose: _/_/_

H. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)

(Three doses of vaccine for females and males 11–26 years of age at 0, 1–2-, and 6-month intervals.)
Immunization (indicate which preparation, if known)
☐ Quadrivalent (HPV4) ☐ Bivalent (HPV2) ☐ 9-valent (HPV9)
a. Dose #1 ___/___/__
b. Dose #2 ___/___/__
c. Dose #3 ___/___/__

I. HEPATITIS A

1. Immunization (Hepatitis A):
   a. Dose #1 ___/___/__
   b. Dose #2 ___/___/__
2. Immunization (Combined Hepatitis A and B vaccine):
   a. Dose #1 ___/___/__
   b. Dose #2 ___/___/__
   c. Dose #3 ___/___/__

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

☐ PCV 13 Date ___/___/___ ☐ PPSV 23 Date ___/___/__

K. MENINGOCOCCAL SEROUGROUP B

(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)
1. MenB-RC (Bexsero) ☐ routine ☐ outbreak –related
a. Dose #1 ___/___/__
b. Dose #2 ___/___/ _
OR
1. MenB-FHbp (Trumenba) ☐ routine ☐ outbreak –related
a. Dose #1 ___/___/__
b. Dose #2 ___/___/__

HEALTH CARE PROVIDER CERTIFICATION

Health Care Provider (please print) _____

Health Care Provider's Signature _____Date _____

Address _____

Telephone _____Fax _____

(Please include Office Stamp)

Student Instructions:

Please return this completed Physical Exam Form and a copy of your immunization record with completed Health Profile form to Health Services via email (Mchealth@moris.edu) or mail to the address below. **Please contact Health Services at 803-934-3256 for any questions.**

Morris College

Attention: Health Services Center

100 West College Street

Sumter, SC 29150