## Congratulations on your acceptance to Johnson & Wales University.

There are specific **Health Services requirements** that you must fulfill before you begin your first semester of study at the university. These requirements include

- A complete Health History Form
- Two doses of the MMR (measles, mumps and rubella) vaccine (or titers if applicable)
- Three doses of hepatitis B vaccine (or titers if applicable — Charlotte Campus does not accept titers)
- Providence Campus: One Tdap dose
- Charlotte Campus: Three doses of tetanus-diphtheria vaccine including one Tdap dose
- Two doses of the chicken pox vaccine (varicella) or titers if applicable, or proof of medical provider-diagnosed disease
- Meningitis vaccine (meningococcal ACWY series). Booster is required if first dose was received prior to age 16.
- **For entering students who are from countries where tuberculosis is highly endemic and who have been residents of the United States for less than five (5) years:** Negative TB test or chest x-ray within the last year. A list of countries where tuberculosis is highly endemic is available upon request from Health Services and as a listed resource in jwuLink.
- **Charlotte Campus only:** Any student who is under the age of 18 upon enrollment must submit proof of the polio vaccine series.

**Recommended Vaccines**

Please check with your medical provider as to whether these vaccines are appropriate for you:

- Meningitis type B vaccine
- Hepatitis A vaccine

**Additional Information**

- JWU courses incorporating foods or beverages may use edible or cleaning products that constitute or contain allergens. Any student enrolling in such a course who has a serious or life-threatening allergy should contact Accessibility Services as needed to discuss the possibility of accommodations or adjustments; further discussion with the relevant faculty member or other administrative personnel may be necessary.
- Instructions on how to submit your health forms can be found on **jwuLink** under **Your New Student Tasks**.
- Information on religious, medical and temporary exemptions can be found on **health.jwu.edu**.
- In addition, if you plan to participate in varsity or club athletics (not intramurals), please complete the Athletics Health History Form at the end of this form.

You are required to return the completed Health History Form inclusive of your immunization history to Health Services by the financial clearance date prior to the semester start date. For students who move into campus housing prior to the financial clearance date, you must return the complete Health History Form to Health Services at least 3 weeks prior to your arrival on campus. You must complete the **Emergency Contacts and Consent to Treat** and **Health History** forms. Your medical provider must complete the **Immunization History** form. If you are under 18, your parent's or legal guardian's signature is required on the bottom of the **Emergency Contacts and Consent to Treat** and **Health History** forms.

Failure to submit a completed Health History Form inclusive of your immunization history by the university's deadline will result in an inability to register for classes or select on-campus housing until the required documentation/records have been submitted. Students will not be allowed to begin the semester on campus without such required documentation.

For additional information about health services at each campus, visit **health.jwu.edu** and select the campus where you will be enrolled. Also, for information regarding accommodations for students with disabilities, please contact Accessibility Services.

We look forward to welcoming you to the university community.

# Emergency Contacts and Consent to Treat

JOHNSON & WALES UNIVERSITY

**Must be completed by student before visiting medical provider.**
**DO NOT LEAVE ANY INFORMATION BLANK.**

**College:** *(check one)*
☐ Arts & Sciences ☐ Health & Wellness
☐ Food Innovation & Technology ☐ Hospitality & Business
☐ Grad Programs

**Residency:** *(check one)* ☐ Residence Hall ☐ Commuter

**Status:** *(check one)* ☐ Full-time ☐ Part-time

**JWU ID Number (REQUIRED):** _____

Entrance Date: Mo _____ Yr _____

Gender: _____

Preferred Name: _____
Last First Middle

Name at Birth: _____
Last First Middle

Student Mobile Phone: _____ Date of Birth: _____
Month Day Year

Permanent Address: _____
Street Apartment Number

_____
City State ZIP

Name of Parent(s)/
Guardian or Spouse: _____

Permanent Address: _____
Street Apartment Number

_____
City State ZIP

Permanent Phone: _____

Work Phone: _____ Mobile Phone: _____

Use as the primary emergency contact: ❑ Permanent ❑ Work ❑ Mobile

**Students with Disabilities:** For information regarding accommodations, please contact the Accessibility Services.

**EMERGENCY CONTACT INFORMATION — REQUIRED**

Name of the Person to be Notified

Relationship to the Student

Home Address

City State ZIP

Home Phone

Mobile Phone

Work Phone

**ALTERNATIVE EMERGENCY CONTACT**

Name of the Person to be Notified

Relationship to the Student

Home Address

City State ZIP

Home Phone

Mobile Phone

Work Phone

## Permission for Treatment

I hereby grant permission to Johnson & Wales University, or its authorized representatives, to furnish such medical care as I, and in the case of a student under the age of 18, my child may require, including examination, immunizations and treatment, and any other medical care that may be required as a result of serious illness, and agree to hold harmless Johnson & Wales University and its agents, Board, directors, employees, officers, trustees and volunteers from any causes of action, claims, damages and/or liabilities, arising out of or resulting from said medical care. I understand and agree that in the event of serious illness, or the need for hospitalization and/or surgery, the university will use reasonable efforts to contact my emergency contacts; however, failure or inability to do so will not prevent the university from providing medical care as necessary.

**Signature** **Date**

**Parent/Guardian Signature** (must be signed by parent or legal guardian if student is under the age of 18) **Date**

# Health History

JOHNSON & WALES UNIVERSITY

**Student Name** _____ **Date of Birth** _____

**Medication Allergies/Reactions** _____

**Food Allergies/Reactions** _____

Do you require the use of an EpiPen?

❑ Yes ❑ No If yes, please bring to campus.

**Other Allergies/Reactions** _____

**Medications** (list all below)

Name _____ Dosage _____ Prescriber _____

Name _____ Dosage _____ Prescriber _____

Name _____ Dosage _____ Prescriber _____

Name _____ Dosage _____ Prescriber _____

**Medical History** (disabilities, injuries, limitations, medical diagnoses and surgeries)

_____

_____

**Personal Health History**

- ❑ ADD/ADHD
- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disorder
- ❑ Back problems
- ❑ Bleeding disorder
- ❑ Cancer
- ❑ Dental Issues
- ❑ Depression
- ❑ Diabetes
- ❑ Eating disorder
- ❑ Endocrine disease
- ❑ Epilepsy or seizure disorder
- ❑ Eye, Ear, Nose or Throat disorder
- ❑ Fainting Spells/Syncope
- ❑ Gastrointestinal disorder
- ❑ Genitourinary disorder
- ❑ Headaches
- ❑ Hearing loss
- ❑ Heart disease
  - ❑ Irregular Heartbeat
  - ❑ Heart Murmur
  - ❑ Arrhythmia
- ❑ Hernia
- ❑ High blood pressure
- ❑ Kidney disorder
- ❑ Liver disorder
- ❑ Lung disorder
- ❑ Mononucleosis
- ❑ Musculoskeletal disorder
- ❑ Neurological disease
- ❑ Respiratory disorder
- ❑ Substance misuse
- ❑ Thyroid disorder
- ❑ Tuberculosis
- ❑ Visual Impairment
- ❑ Other:

_____

_____

**Hospitalization/Surgery**

Have you ever been hospitalized or had surgery? If yes, explain below:

Hospitalization/Surgery _____ Date _____

Hospitalization/Surgery _____ Date _____

**Family History**

_____

❑ Sudden death of a family member under 50 years of age of nontraumatic cause, family history of hypertrophic cardiomyopathy, long QT wave or Marfan's Syndrome?

**I attest the self-reported information is accurate and I accept medical treatment will be rendered based on the information provided.**

Student Signature _____ Date _____

Parent/Guardian Signature if under 18 _____ Date _____

**Please attach additional forms if needed.**

# Immunization History

JOHNSON & WALES UNIVERSITY

**Official immunization documentation from your primary care provider can be used in lieu of this form. International students, please use this form.**

**Medical provider must COMPLETE and SIGN this form.**

Patient Name: _____ Date of Birth: _____
Month Day Year

**REQUIRED**

**Negative TB test or chest x-ray within the last year is required for entering students who are from countries where tuberculosis is highly endemic and who have been residents in the United States for less than five (5) years. A list of countries where tuberculosis is highly endemic is available upon request from Health Services.**

MM/DD/YY _____ Results _____

**Tdap**

#1 MM/DD/YY _____

**DTP History** *(Charlotte only)*

#1 MM/DD/YY _____ #2 MM/DD/YY _____ #3 MM/DD/YY _____

**MMR (Measles, Mumps, Rubella)**

*Two doses required after first birthday*

#1 MM/DD/YY _____ or

#2 MM/DD/YY _____

**Titers (if applicable)**

**Please Attach Lab Work**

❑ MEASLES ❑ Immune ❑ Not Immune

❑ MUMPS ❑ Immune ❑ Not Immune

❑ RUBELLA ❑ Immune ❑ Not Immune

**Hepatitis B Vaccine Series** *(required)*

#1 MM/DD/YY _____

#2 MM/DD/YY _____

#3 MM/DD/YY _____

**Titers (Providence Campus only)** ❑ Immune ❑ Not Immune

**Please Attach Lab Work**

**Chicken Pox Vaccine (Varicella)** *(required if not previously diagnosed by a medical provider)*

Date of infection: MM/DD/YY _____ or

#1 MM/DD/YY _____

#2 MM/DD/YY _____

**Titers (if applicable)** ❑ Immune ❑ Not Immune

**Please Attach Lab Work**

**Meningitis Vaccine** *(required for all students under age 22)*

If you received your first dose prior to age 16, a booster is required: Vaccine MM/DD/YY _____

Booster MM/DD/YY _____

**Polio Vaccine Series** *(if under age 18 — Charlotte Campus only)*

#1 MM/DD/YY _____ #2 MM/DD/YY _____ #3 MM/DD/YY _____

**RECOMMENDED**

**Meningitis Serogroup B Vaccine Series** *(Please check with your medical provider as to whether the Meningitis Type B Vaccine is appropriate for you)*

Check one ❑ Trumenba or ❑ Bexsero

#1 MM/DD/YY _____ #2 MM/DD/YY _____ #3 MM/DD/YY _____

**Hepatitis A Vaccine Series**

#1 MM/DD/YY _____ #2 MM/DD/YY _____

_____

**MEDICAL PROVIDER'S SIGNATURE** **DATE**

_____

Print Name Phone Number

_____

Street Address

# Athletics Health History Form

JOHNSON & WALES UNIVERSITY

**This section must be completed if you will be an NCAA varsity athlete, equestrian athlete, or if you intend to participate in club athletics. PLEASE DISREGARD IF YOU ARE NOT AN ATHLETE.**

Have you ever been denied participation in a sport? When? _____ Why? _____

Do you suffer from frequent nosebleeds? _____

Have you ever had a concussion? _____ Number of times: _____

## ORTHOPEDIC INFORMATION

| YES | NO | | WHEN | R or L |
|---|---|---|---|---|
| **Head and Neck Information** | | | | |
| ❑ | ❑ | Have you ever had a head/neck injury (non-concussion)? | _____ | _____ |
| ❑ | ❑ | Were you ever hospitalized for a head/neck injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had head or neck surgery? | _____ | _____ |
| Explain: _____ | | | | |
| **Shoulder/Arm/Hand/Finger Information** | | | | |
| ❑ | ❑ | Have you ever had a shoulder injury? | _____ | _____ |
| ❑ | ❑ | Have you ever dislocated or separated your shoulder? | _____ | _____ |
| ❑ | ❑ | Have you ever had an elbow injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had a hand, wrist or finger injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had shoulder, arm, hand or finger surgery? | _____ | _____ |
| Explain: _____ | | | | |
| **Back and Hip Information** | | | | |
| ❑ | ❑ | Have you ever suffered a back injury? | _____ | _____ |
| ❑ | ❑ | Do you have scoliosis or any other spinal defect? | _____ | _____ |
| ❑ | ❑ | Have you ever had a hip injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had back or hip surgery? | _____ | _____ |
| Explain: _____ | | | | |
| **Knee Information** | | | | |
| ❑ | ❑ | Have you ever had a knee injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had knee surgery? | _____ | _____ |
| Explain: _____ | | | | |
| **Ankle and Foot Information** | | | | |
| ❑ | ❑ | Have you ever had an ankle injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had a foot injury? | _____ | _____ |
| ❑ | ❑ | Have you ever had ankle or foot surgery? | _____ | _____ |
| Explain: _____ | | | | |
| **Bone and Muscle Information** | | | | |
| ❑ | ❑ | Have you ever had shin splints? | _____ | _____ |
| ❑ | ❑ | Have you ever had a stress fracture? Where? | _____ | _____ |
| ❑ | ❑ | Have you ever fractured a bone? Where? | _____ | _____ |
| ❑ | ❑ | Have you ever had any other bone problems? Explain: _____ | | |
| ❑ | ❑ | Do you have any pins, screws or plates in your body? Where? _____ | | |

Please further explain any "yes" answers, if necessary. _____

_____

_____

Do you have any other orthopedic problem we should be aware of? _____

## ASSUMPTION OF RISK, CONSENT TO TREAT AND CONTINUING OBLIGATION TO UPDATE

## PLEASE DISREGARD IF YOU ARE NOT AN ATHLETE.

I, _____ , am aware that playing or participating in any sport is a dangerous activity involving risk of injury, which includes, but isnot limited to, death, permanent disability, neck and spinal cord injuries, brain injuries, injuries to vital organs, injuries to bones, joints, ligaments, muscles and tendons. By signing below, with the full understanding of the risks associated with participating in sports, I voluntarily agree to assume any and all risks associated with training, preparing for, participating in, or traveling to or from any sport or athletic event, or program organized by or through Johnson & Wales University prior to or during my enrollment at the university. I hereby agree on behalf of myself, my administrators, assigns, heirs, representatives and successors to hold harmless Johnson & Wales University and its agents, Board, directors, employees, officers, representatives, trustees and volunteers ("university parties") from any causes of action, claims, damages and/or liabilities related thereto. Additionally, by signing below, with the full understanding of the risks associated, I consent and give permission to the university parties and their assigns to proceed with and make decisions with respect to any medical treatment and/or care deemed necessary as a result of any injury or illness that I may suffer during my training, preparation for, participation in, and/or travel to or from any sport or athletic event or program organized by or through Johnson & Wales University prior to or during my enrollment at the university. On behalf of myself, administrators, assigns, heirs, representatives and successors, I hereby agree to hold harmless the university parties from any causes of action, claims, damages and/or liabilities arising out of or resulting from said medical treatment and/or care.

I understand that during my enrollment at Johnson & Wales University, I have a continuing obligation to update Johnson & Wales University and its athletics department of any changes to my medical history and/or to any information contained in this Athletic Health History Form, and I hereby agree to hold harmless the university parties from any causes of action, claims, damages and/or liabilities arising out of or resulting from my failure to do so.

In addition to the foregoing, I acknowledge that all of the information contained in this Athletic Health History Form is true and correct to the best of my knowledge and belief.

**Student's Signature** **Date**

**Parent Signature** (if student is under 18 years of age) **Date**

# Pre-participation Athletic Screening

JOHNSON & WALES UNIVERSITY

**PLEASE DISREGARD IF YOU ARE NOT AN ATHLETE.**

**Medical provider must COMPLETE and SIGN this form.**

**Orthopedic Assessment**

Height: Weight:

Head and Neck: Knees: Shoulders:

Back: Ankles: Hips:

Elbows: Feet: Wrists:

**Cardiovascular Screening**

1. Precordial Auscultation (please note any heart murmur) Supine: Standing:

2. Bilateral Femoral Artery Pulses (to exclude coarctation of aorta):

3. Indications of Marfan's Syndrome: No: Yes (describe):

4. Sitting Brachial Pressure:

Any problems that need referrals?

Full Participation: Special Considerations:

Limited Participation: No Participation:

Physician's Comments:

**Physician's Signature** **Date**

Contact Information