Welcome! As a ministry to the Palm Beach Atlantic University community, our mission is to promote physical, mental and spiritual health and well-being. Our desire is to provide all health services and programs from a Christ-centered perspective, enabling each person to fulfill academic, personal and spiritual goals.

The Health and Wellness Department provides a variety of both free and low cost medical and counseling services. We also offer a wide range of health programming to the university community including educational programs, blood drives in cooperation with area community blood centers and an annual flu shot clinic.

We look forward to serving you!

Please use this checklist to confirm you have submitted all of your required health forms to Health and Wellness.

DEADLINE FOR FORMS IS AUGUST 1st (Fall Semester) and DECEMBER 1st (Spring Semester)!

- **Health Information Form**
  Required for all students.
  Completed by student.

- **TB Risk Screening Form**
  Required for all students.
  Page 1 is completed by student. Page 2 is completed by physician, if needed. Submit TB test results, if required.

- **Immunization Form**
  Required for all Full-Time Day Undergraduate students: MMR1 & MMR2.
  Additional requirements if living on campus: Hep B 1, Hep B 2, Hep B 3, Meningococcal
  Completed by a physician. Must have office stamp.
  *School of Nursing and School of Pharmacy may have additional requirements.*

- **Physical Form**
  Required for all Full-Time Day Undergraduate students.
  Completed by a physician in the last 12 months. Must have office stamp.

- **Student Health Insurance**
  PBA requires all Full-Time Day Undergraduate, Pharmacy and International students to provide evidence of adequate health insurance coverage. These students will be automatically billed and enrolled in the PBA Student Health Insurance Plan unless a waiver is submitted before the posted deadline. Go to the Health and Wellness Department page on [my.pba.edu](http://my.pba.edu) for more information. This is an annual requirement. **DEADLINE TO WAIVE IS SEPTEMBER 15th (Fall Semester) and JANUARY 15th (Spring Semester)!**

For more information visit us at [www.pba.edu](http://www.pba.edu) > myPBA > Departments > Health and Wellness
The primary purpose of the Health Information Form is to make necessary health care information available to us while you are a student at Palm Beach Atlantic University. It is required for ALL students attending classes on the main PBA campus.

1. DEMOGRAPHIC INFORMATION

Legal Name: _____________________________ PBA ID#: _____________________________

Cell Phone: _____________________________ Home Phone: _____________________________

Home Address: _______________________________________________________________

Street or PO Box: __________________________________ City: _____________________________

State: _____________________________ Zip Code: _____________________________

Date of Birth: __/__/____ Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married

Check One: ☐ Commuter ☐ Living on Campus ☐ Residence Hall Name

Check One: ☐ FT Day Undergraduate ☐ Graduate/Add'l Bachelors ☐ Evening/Part-Time ☐ Pharmacy/DNP ☐ Non-Degree

New or Transfer Student starting PBA: ☐ Fall 20__ ☐ Spring 20__ ☐ Summer 20__ Former PBA Student: Yes or No

2. EMERGENCY CONTACT INFORMATION

Person to contact in case of emergency:

Name: _____________________________________________________ Phone: _____________________________

Relationship to you ____________________________________________

3. HEALTH INFORMATION (Please do not leave blank - put N/A. Attach additional sheet if more room for documentation is needed.)

Current physical or mental health conditions which may impact your experience at PBA (chronic or recurring conditions, disabilities, etc):

________________________________________________________________________________________

Current medications:

________________________________________________________________________________________

Past serious injuries, surgeries, medical or mental health conditions:

________________________________________________________________________________________

Allergies (medications, foods, substances):

________________________________________________________________________________________

4. HEALTH INSURANCE REQUIREMENT NOTIFICATION

PBA requires all Full-Time Day Undergraduate, International and Pharmacy students to provide evidence of adequate health insurance coverage. These students will be automatically billed and enrolled in the PBA Student Health Plan unless a waiver providing information regarding alternate coverage is submitted by the posted deadline. The deadline date and waiver information can be found on the Health and Wellness page of myPBA. This is an annual requirement.

5. CONSENT FOR MEDICAL TREATMENT

I hereby grant permission to Palm Beach Atlantic University Health and Wellness personnel, counselors, and representatives to render and/or obtain treatment (medical/surgical/emotional) necessary to my health and well being. I also permit hospitalization, if necessary, and I understand that the expenses for such treatments and/or hospitalizations shall be my responsibility.

Student Signature: _____________________________ Date: _____________________________

(Signature of Parent or Guardian if student is under 18 years of age)
If you answered YES to any of the above questions, Palm Beach Atlantic University requires you to submit evidence of TB Testing done within the past 6 months. Your medical provider will need to complete Page 2: TB Clinical Assessment. Regardless of risk, Page 1 is required to be submitted to Health and Wellness prior to the start of your first semester. Page 2 should only be included if Clinical Assessment is required.

If the answer to all of the above questions is NO, no further testing or action is required.
TB Clinical Assessment by Health Care Provider

(This form is only required if student answered YES to any of the questions on Page 1)

Clinicians should review and verify the information answered on Page 1: TB Risk Screening. Students answering YES to any of the questions are candidates for either Mantoux tuberculin skin test (TST aka PPD) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented. A chest X-ray alone cannot be used to test for TB exposure, it is only indicated if a TST or IGRA is positive.

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease?  ❑ Yes ❑ No
If no, proceed to 2 or 3.
If yes, check below, then proceed with additional evaluation to exclude active tuberculosis disease.

❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
❑ Coughing up blood (hemoptysis)
❑ Chest pain
❑ Loss of appetite
❑ Unexplained weight loss
❑ Night sweats
❑ Fever

2. Tuberculin Skin Test (TST): Date Given: ____________
   Date Read: ____________    Result: ________ mm of induration  
   Interpretation: ❑ Positive ❑ Negative

3. Interferon Gamma Release Assay (IGRA)

   Date Obtained: ____________ (specify method)  ❑ QFT-GIT  ❑ T-Spot  ❑ Other_____  
   Result: ❑ Negative ❑ Positive ❑ Indeterminate ❑ Borderline (T-Spot only)

Treatment Plan: __________________________________________________________________________
_________________________________________________________________________________________

Chest X-ray: (Required if TST or IGRA is positive, cannot be used as sole indicator for TB infection)
Date of Chest X-ray: ________________    Result:  ❑ Normal ❑ Abnormal

Provider Signature: ___________________________________________ Date: _________________________
Official Office Stamp:________________________
**Immunization Form**

**HEALTH AND WELLNESS**

Last Name __________________ First Name __________________

PBA ID# __________________

Birthdate: _____/_____/_______ Current Age: ______

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Please document ALL vaccines received even if not required.

<table>
<thead>
<tr>
<th>REQUIRED for</th>
<th>VACCINE or TEST</th>
<th>Date MM/DD/YY</th>
<th>Notes/Titer Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL Full-Time undergraduates born after 1956</td>
<td>Measles, Mumps, Rubella #1 (MMR1)</td>
<td></td>
<td>or Positive Titer Dates</td>
</tr>
<tr>
<td>List all dates if given separate</td>
<td>Measles, Mumps, Rubella #2 (MMR2)</td>
<td></td>
<td>Measles___________________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mumps____________________________</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rubella___________________________</td>
</tr>
<tr>
<td>Additional requirements for students</td>
<td>Hepatitis B #1 (Hep B 1)</td>
<td></td>
<td>or Positive Titer Date</td>
</tr>
<tr>
<td>living on campus</td>
<td>Hepatitis B #2 (Hep B 2)</td>
<td></td>
<td>#3 not needed if 2-dose series given. Please indicate “2 dose” if applicable</td>
</tr>
<tr>
<td>Per Florida Statute 1006.69 resident students</td>
<td>Hepatitis B #3 (Hep B 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>must receive these vaccines or decline.*</td>
<td>Meningococcal (ACWY) #1</td>
<td>#2 recommended if #1 was given before age 16</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningococcal (ACWY) #2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Sign below if you are choosing to decline the following vaccines:

- I have read the information about Hepatitis B and decline the **Hepatitis B vaccine**. ([www.cdc.gov/vaccines](http://www.cdc.gov/vaccines))

  ____________________________
  Signature of student or parent/legal guardian if under 18 years of age

  ____________________________
  Date

- I have read the information about Meningococcal Meningitis and decline the **Meningitis vaccine**. ([www.cdc.gov/vaccines](http://www.cdc.gov/vaccines))

  ____________________________
  Signature of student or parent/legal guardian if under 18 years of age

  ____________________________
  Date

Recommended

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>Date MM/DD/YY</th>
<th>VACCINE</th>
<th>Date MM/DD/YY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicella #1</td>
<td></td>
<td>HPV #1</td>
<td></td>
</tr>
<tr>
<td>Varicella #2</td>
<td></td>
<td>HPV #2</td>
<td></td>
</tr>
<tr>
<td>Td</td>
<td></td>
<td>HPV #3</td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td>TB TESTING</td>
<td></td>
</tr>
<tr>
<td>Meningococcal (MenB) #1</td>
<td></td>
<td>PPD Skin Test</td>
<td>Date__________</td>
</tr>
<tr>
<td>Meningococcal (MenB) #2</td>
<td></td>
<td>Measurement</td>
<td>__________mm</td>
</tr>
<tr>
<td>Meningococcal (MenB) #3</td>
<td></td>
<td>TB Chest X-Ray</td>
<td>Date__________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Result________</td>
<td></td>
</tr>
<tr>
<td>Hepatitis A #1</td>
<td></td>
<td>IGRA Blood Test</td>
<td>Date__________</td>
</tr>
<tr>
<td>Hepatitis A #2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Yellow Fever</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: School of Nursing and School of Pharmacy may have additional requirements

Provider Signature __________________________ Date ________________

Print Name __________________________ Phone __________________________

Please return form to PBA Health and Wellness Center • P.O. Box 24708 • West Palm Beach, FL 33416-4708

Email: Health_Wellness@pba.edu • Fax (561) 803-2499 • Phone (561) 803-2576
### A. Vital Statistics:

| Gender: □ Male □ Female | Ht. _______ | Wt. _______ | Pressure _______/______ | Temp. _______ | Pulse _______ |

### B. Health Examination: Normal = N; Abnormal = A

<table>
<thead>
<tr>
<th>Circle</th>
<th>Comments: Abnormal Findings; label by number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Appearance</td>
<td>N A</td>
</tr>
<tr>
<td>2. Skin/Nose</td>
<td>N A</td>
</tr>
<tr>
<td>3. Head/Scalp</td>
<td>N A</td>
</tr>
<tr>
<td>4. Eyes</td>
<td>N A</td>
</tr>
<tr>
<td>5. Visual Acuity (R&amp;L)</td>
<td>N A</td>
</tr>
<tr>
<td>6. Ears</td>
<td>N A</td>
</tr>
<tr>
<td>7. Auditory Acuity (R&amp;L)</td>
<td>N A</td>
</tr>
<tr>
<td>8. Nose/Throat</td>
<td>N A</td>
</tr>
<tr>
<td>9. Mouth, Teeth and Gums</td>
<td>N A</td>
</tr>
<tr>
<td>10. Chest/Lungs</td>
<td>N A</td>
</tr>
<tr>
<td>11. Heart</td>
<td>N A</td>
</tr>
<tr>
<td>12. Abdomen</td>
<td>N A</td>
</tr>
<tr>
<td>13. Genitals (optional)</td>
<td>N A</td>
</tr>
<tr>
<td>14. Musculo-Skeletal</td>
<td>N A</td>
</tr>
<tr>
<td>15. Neurological</td>
<td>N A</td>
</tr>
<tr>
<td>16. Alertness</td>
<td>N A</td>
</tr>
<tr>
<td>17. Emotional/Mental (Behavior Problems)</td>
<td>N A</td>
</tr>
<tr>
<td>18. Handicap, Physical/Other (Specify)</td>
<td>N A</td>
</tr>
<tr>
<td>19. Activity Restrictions (Specify)</td>
<td>N A</td>
</tr>
<tr>
<td>21. Nutrition</td>
<td>N A</td>
</tr>
<tr>
<td>22. Other</td>
<td>N A</td>
</tr>
</tbody>
</table>

### C. Health History: (serious illnesses, injuries: explain)

__________________________________________

### D. Medications: (Please list all current medications)

__________________________________________

### E. Laboratory: (if clinically indicated)

_______________________________________________________________________

### F. Verification: (check all that apply)

- □ I certify that this student may participate in all university activities including inter-collegiate athletics.
- □ I certify that this student may participate in all university activities with the following exceptions and/or limitations:

### G. General Comments:

__________________________________________