***RISD Health Services*, 2 College Street. Providence, RI 02903.**
Phone: (401) 454-6625. Fax: (401) 454-6628.

Dear Incoming Student,

Welcome to RISD! Please follow the instructions to complete this packet, and return by the deadline.

INCOMING FALL STUDENTS- Graduate and Undergraduate:
The deadline for this packet is July 1st . All documents must be received by this date.

Please use this checklist to assure all required documentation has been completed:

- Form 1. Physical Examination Form (Physician signature required)
- Form 2. Student General Information Form (Student or guardian must complete)
- Form 3. Student Immunization Form with Records (Physician signature required)
- Form 4. Tuberculosis Screening Form (Physician signature required)
- Form 5. Tuberculosis Screening Questionnaire

Please be aware that your registration is not considered complete until you're completed and signed Health Form has been received and verified by Health Services.

This may result in dismissal from their program.

Students can manage their health information with Health Services by printing a copy of New Student Health Forms and bring Forms 2, 3, 4 and 5 to your Primary care provider. Upload all completed forms to the Patient Portal, an online service for conveniently and confidentially submitting health and immunization records.

*Please Note: When uploading forms in the portal:

1. image files **MUST** be .gif, .png, .tiff, .tif, .jpg, .jpeg
2. Documents MUST be .txt, .pdf
3. File names should NOT have special characters (% $...). Keep file name simple and short.

We appreciate your cooperation in returning these forms by the deadline and look forward to your arrival on campus.

Sincerely,
RISD Health Services

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Form 1: Physical Examination *(To be completed by a Provider)*

Date of Exam ___/___/___

Last Name _____ First Name _____ Preferred Name_____ Middle Initial_____
Sex Assigned at Birth_____ Gender Identity_____
DOB / /

ALLERGIES & REACTION TO:

Medication:	Food/Other:
_____	_____

MEDICATIONS/SUPPLEMENTS:

List all prescription, over-the-counter medications and supplements used on a regular basis

Medication Name	Dosage & Frequency	Reason
_____	_____	_____
_____	_____	_____

EXAMINATION

	Normal	Abnormal	Findings
General Appearance	O	O	_____
Skin	O	O	_____
Eyes	O	O	_____
Ear, Nose & Throat	O	O	_____
Neck	O	O	_____
Cardiovascular	O	O	

Corrected Vision (Circle): Y N
Contacts: Y N
Glasses: Y N

Height_____
Weight_____
BMI_____

List any surgical procedures:
_____
_____

Is patient now under treatment for any medical condition? Yes_____No _____
Recommendations_____

Is patient now under treatment for any mental health condition? Yes___No
Recommendations_____

MEDICAL HISTORY

Have your **relatives** ever had the following?

	Yes	No	Relation
Cancer	O	O	
Tuberculosis	O	O	
Diabetes	O	O	
Kidney Disease	O	O	
Heart Disease	O	O	
Intestinal disorder	O	O	
Asthma/Hay fever	O	O	
Autoimmune disorder	O	O	
Epilepsy, Seizures	O	O	

Have **you** had any of the following?

	Yes	No	History
Recurrent headache/migraine	O	O	
Head injury/concussion	O	O	
Fainting spells/seizure	O	O	
ADD /learning disability	O	O	
Substance abuse	O	O	
Eating Disorder	O	O	
Chronic cough	O	O	
Tuberculosis/ positive PPD	O	O	
Digestive disorder	O	O	
Hepatitis/Liver disease	O	O	
Cancer	O	O	
Kidney/bladder disease	O	O	
Joint disease/injury	O	O	

Provider Name (PRINT):_____

Provider Signature:_____

Address:_____

Phone:_____

Fax: _____

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Form 2: Student General Information Form

Last Name_____ **First Name**_____ **Preferred Name**_____

DOB:_____ Place of Birth:_____ How long have you lived in USA?_____

Home Address_____ Student Cell Phone Number:_____

Required: Circle program student is enrolled in below:
Undergraduate | Graduate | Exchange Program | Summer Studies Program | Pre-College

CONSENT FOR TREATMENT

I hereby grant permission to the College Nurse Practitioner and/or Physician, of the Rhode Island School of Design or his / her authorized representatives, to furnish such medical care as my son or daughter _____(student's full name) may require, including examinations, treatment, immunizations, etc. This permission is conditioned on the understanding that in the event of a serious illness or the need for hospitalization and /or major surgery, the college will use all reasonable efforts to contact me. Failure of such efforts, however, should not prevent the College from providing such emergency treatment as may be necessary for the best interest in the life of _____ (student's full name). I understand that to provide the best possible care for students, the clinician may share information, when appropriate, with professionals within Counseling Services and Student Health Services for the purposes of diagnosis and treatment planning. I also acknowledge that the Rhode Island School of Design must abide by both Rhode Island State Law and the individual policies of area hospitals with regard to consent to medical treatment of a minor. I understand that in the event of a medical emergency I may be contacted directly by hospital staff as necessary for the treatment or release of my son / daughter named above.

Signature of Student (over 18):_____ Date: ____
Signature of Parent or Guardian:_____ Date:____
(If student under 18 at beginning of academic year)

EMERGENCY CONTACT INFORMATION

Name	_____	Name	_____
Relationship	_____	Relationship	_____
Address	_____	Address (USA)	_____
Home phone	_____	Home phone	_____
Cell phone	_____	Cell phone	_____
Work phone	_____	Work phone	_____

OFF-CAMPUS ADDRESS (If Applicable)

Street:_____ Apt#:_____ City: _____State:____Zip Code:_____

HEALTH INSURANCE POLICY INFORMATION

Company Name — Company Address (***must be a US address***)

Policy Number — Group Number — Pre-Certification Telephone

Subscriber's Name — Date of Birth

Check here if enrolled in RISD Student Health Insurance Policy with University Health Plans

- United Health Student Resources Insurance

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Form 3: Student Immunization Form

REQUIRED FOR REGISTRATION.

Not valid without Provider signature
Provider Complete below & attach copy of immunization record or laboratory titer results

Last Name_____ First Name_____DOB:_____

TDap/Td

TDAP (within last 10 years) Date: _____/_____/_____ **AND** **Td (within last 10 years)** Date: _____/_____/_____

(*If Tdap date is > 10 yrs from date of enrollment must provide date of recent Td booster)

MMR

MMR # 1 Date: _____/_____/_____

MMR # 2 Date: _____/_____/_____

OR

MMR TITER Date: _____/_____/_____

**(2 doses Minimum of 4 weeks between doses
1st dose given after 1st birthday)**

HEPATITIS B

Hep B #1

(3 doses OR Positive titer. Minimum 4 weeks between doses 1 and 2 Minimum 8 weeks between doses 2 and 3 Minimum 16 weeks between 1 and 3)

VARICELLA

Varicella # 1 date: **Varicella # 2 date:** **OR** **Varicella Illness date:** **OR** **Varicella TITER** Date: _____/_____/_____

**(Minimum of 3 months between doses if 1-12 years old
Minimum of 4 weeks between doses if 13 or older)**

Date:

MENINGITIS

(Booster Dose required if dose 1 was given before 16 years old)

Type:_____

Date: _____/_____/____ Booster Date:_____/____/____

Provider Name (PRINT):_____

Provider Signature:_____

Address:_____

Phone:_____

Fax: _____

RECOMMENDED: HEPATITIS A

HEPATITIS A # 1 *Date:* _____/_____/____

HEPATITIS A # 2 *Date:* _____/_____/_____

The State of Rhode Island requires documentation of immunity in order to register for college. Persons born before 1957 are exempt from this requirement.
Religious & Medical Exemption forms must be obtained from The State of Rhode Island Department of Health's website. Please complete and submit with this paperwork.

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Form 4: Tuberculosis (TB) Screening (*Not valid without Provider signature)*

Attach copy of chest x-ray or treatment plan if applicable

Date of Birth:_____/_____/_____

Last Name: First Name Middle Initial

TEST RESULTS – Select One

- ○ TB Screening Questionnaire has been completed and reviewed.
  - ○ (See Attached Form 4)
- ○ No risk factors were identified and the Tuberculin Skin Test was not performed.
- ○ A risk factor has been identified and the Tuberculin Skin Test or IGRA was performed.
- ○ Received BCG vaccine in childhood.

IGRA (Interferon Gamma Release Assay)

(**Recommended if received BCG vaccine**)

Date obtained ___/___/___

Result: Positive_____
Negative_____

PPD (Mantoux) Placed: ____/____/____

PPD (Mantoux) Read: ____/____/____

Result:_____ (in mm)

POSITIVE TUBERCULIN SKIN TEST RESULT

If Tuberculin Skin Test is Positive, now or previously, complete the following requirements:

Date of Positive PPD: ____/____/____

Chest X-ray:

Attach copy of report

- ○ Normal
- ○ Abnormal

Result: _____
_____

Provider Name (PRINT): _____

Provider Signature:_____

Address:_____

Phone:_____

Fax: _____

Classification of the TB Skin Test Reaction

- *An **induration of 5 or more millimeters** is considered positive in*
- *Hive infected persons*
- *A recent contact of a person with TB disease*
- *Persons with fibrotic changes on chest radiograph consistent with prior TB*
- *Patients with organ transplants*
- *Persons who are immunosuppressed for other reasons (e.g., taking the equivalent of >15 mg/day of prednisone for 1 month or longer, taking TNF-a antagonists)*

- *An **induration of 10 or more millimeters** is positive in*
- *Recent immigrants (<5years) from high prevalence countries*
- *Injection drug users*
- *Residents and employees of high risk congregate settings*
- *Mycobacteriology laboratory personnel*
- *Persons with clinical conditions that place them at high risk*
- *Children <4 years of age*
- *Infants, children and adolescents exposed to adults in high risk categories*

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Form 5: Tuberculosis (TB) Screening Questionnaire (To be completed by Student)

Please answer the following questions:

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

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) ❑ Yes ❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 populations.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) ❑ Yes ❑ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? ❑ Yes ❑ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? ❑ Yes ❑ No

If the answer is YES to any of the above questions, RISD requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

* *The significance of the travel exposure should be discussed with a health care provider and evaluated.*

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LOCATION

Homer Hall (lower Quad)

401-454-6625

M-F 8:30am to 4:30pm

https://info.risd.edu/health-services/

Except for emergencies, hours of operation are by appointment only.

HEALTH INSURANCE

All students enrolled must provide proof of insurance that meets the guidelines outlined in the enclosed Health Insurance Information Sheet. Please carefully read the requirements before filling out the Health Insurance Information Form.

EMERGENCIES

When Health Services & the Counseling Center are closed, contact Public Safety at

401-454-6666 or ext. 6666.

A Public Safety Emergency Medical Technician (EMT) will respond.

URGENT CARE

East Side Urgent Care: 1195 N. Main St. Providence 401-861-3782

SPECIALISTS

When necessary, transportation to specialists in the community can be arranged through Health Services via cab. Costs for transportation to medical facilities off-campus are the student's responsibility. Students are financially responsible for any medical services received off-campus.

SPECIAL CONSIDERATIONS

Parents or guardians who feel that their son or daughter may require special medical or mental health related considerations must arrange for specialized care with a provider in the community. Parents or guardians are encouraged to discuss these issues with Health Services before the student arrives on campus.

MEDICATIONS

Students are expected to manage their supply and administration of all medications.

LOCAL PHARMACIES

Walgreens: 1140 N. Main St. Providence 401-278-4901

CVS 100 Francis St. Providence 401-270-4440

COUNSELING & PSYCHOLOGICAL SERVICES

RISD's Counseling & Psychological Services can provide psychological assessment and triage. If on-going care is needed, counseling center staff will provide the student with a referral to a provider in the community.