NOTRE DAME UNIVERSITY
LOUAIZE
جامعة سيدة اللويزة
GAUDIUM DE VERITATE

STUDENT MEDICAL RECORD

DEPARTMENT OF COUNSELING & HEALTH

Medical House Decision
Complete Health Form: ☐ Yes ☐ No
Incomplete for: _____

DIRECTIONS

Dear new student,

Completing this medical form will permit the NDU medical team to offer you better care during your studies at the university. Every new student will get an assessment of his/her health status prior to admission to NDU. This form must be completed, signed by the student and his/her personal physician, and submitted before or upon registration. **A completed medical form is vital for the processing of your registration. Students will not be registered without submitting their medical record to the medical house (MH).** Failure in submitting the student medical record (SMR) prevents students from getting their NDU identification card (ID).

The MH at NDU shall follow up on students with abnormal results of the health assessment and on vaccination:

- To protect the NDU environment and to ensure that all new students are in good physical and mental health and are at minimal risk of exposure to communicable diseases.
- To make sure that the MH has an initial health assessment for all NDU students.
- To ensure that all students in the medical fields (Medical Laboratory and Nursing) are immune to Hepatits B, and students in dorms against Meningitis.

All new students shall be screened for positive TST (Tuberculine Skin Test) during pre-registration or registration period. The nurse at NDU administers the TST screening through a campaign during the pre-registration or registration period. Two days later, the new student comes to the MH for TST reading. Positive results require further investigations and an NDU physician's appointment for follow up.

After that, new students will be medically cleared, may get their IDs and use the MH services for any health reason. Your health is vitally important and your time is heavily scheduled, therefore the MH offers you medical care on an open-access, walk-in or appointment basis during your time at NDU.

After the registration period, all SMRs are entered on the electronic medical record of NDU.
Your medical information is strictly confidential and will not be released to anyone without your consent. In situations where student's safety is immediately in danger as a result of an important health issue, medical information may be shared with appropriate persons to ensure adequate medical care.

PERSONAL INFORMATION

Student ID number _____ Major _____

_____ _____ _____
Family name First name Middle/Father name

Date of birth _____ Place of birth _____

Nationality 1. _____ 2. _____

Gender ☐ Male ☐ Female Marital Status _____

Email _____ NDU Dorms ☐ Yes ☐ No

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____ Relationship _____

Address _____

Home phone number _____ Office phone _____

Mobile _____ Email _____

MEDICAL INFORMATION

Physical Examination

Height _____ Weight _____ BMI _____ BP _____ Pulse _____

Other findings _____

Smoking habit ☐ Yes ☐ No If yes, please give relevant details _____

Allergical reactions ☐ Yes ☐ No If yes, please give relevant details _____

Blood type ☐ A ☐ B ☐ AB ☐ O Rhesus ☐ Positive ☐ Negative

Hospitalization

Have you ever been hospitalized? ☐ Yes ☐ No

If yes, please list year(s) and condition(s) _____

Medication (please include over the counter drugs, herbs or vitamins)

Are you currently on medication? ☐ Yes ☐ No

If yes, please list the medication(s), dose(s) and number of tablets/day _____

_____

Insurance company

Name and address _____ Policy number _____ Expiry date _____

HEALTH HISTORY

Have you ever had or do you have now any medical problem? ☐ Yes ☐ No If yes please specify:

- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Hepatitis
- ☐ Skin rash
- ☐ Tuberculosis
- ☐ Varicella (chicken pox)
- ☐ Heart murmur
- ☐ High or low blood pressure
- ☐ Kidney problem
- ☐ Rapid or irregular heart beat
- ☐ Asthma
- ☐ Vision problem
- ☐ Hearing problem
- ☐ Depression
- ☐ Anxiety/panic attack
- ☐ Eating disorder
- ☐ Attention / learning disorder
- ☐ Alcohol use
- ☐ Drug use
- ☐ Epilepsy or convulsion
- ☐ Head injury
- ☐ Loss of consciousness
- ☐ Back pain
- ☐ Ulcer
- ☐ Arthritis
- ☐ Recent weight gain/loss
- ☐ Other, Please give relevant details _____

_____

Family History (cardiometabolic diseases, cancer, psychological disorders or others) ☐ Yes ☐ No

If yes, please specify _____

RECORDS OF IMMUNIZATIONS

[1]Measles/Mumps/Rubella	☐ Yes	☐ No	Dates _____
[1]Diphteria/Tetanus/Pertussis	☐ Yes	☐ No	Dates _____
[1]Polio	☐ Yes	☐ No	Dates _____
[1]HepatitisB	☐ Yes	☐ No	Dates _____
[1]Varicella	☐ Yes	☐ No	Dates _____
or confirmed chicken pox disease	☐ Yes	☐ No	
[2]Meningococcal Vaccine	☐ Yes	☐ No	Date _____
BCG vaccine	☐ Yes	☐ No	Date _____
PPD (within the past 12 months)	☐ Yes	☐ No	If yes, specify: Date _____ Diameter _____

- [1]These vaccins are required for all students.
- [2]Meningococcal vaccine is required for all students in dorms.

Physician's Signature and Stamp	Date	Student's Signature