| Title: **New Students Registration/Vaccination** | Index Number: **ACC-FAM- 006** |
|---|---|
| Scope of application: **New AUB students** | Original: **01.01.2006** Reviewed on: **24.07.2013** Next Review date: **24.07.2016** |

## 1. *Policy*

**1.1** Every new student shall get an assessment of his/her health status or a Physical examination prior to admission to University to ensure that he/she is screened for tuberculosis and immune against other communicable diseases such as Tetanus, Measles, Mumps, Rubella, Varicella, and Meningitis.

**1.2** Failure in submitting the medical records prevents students from getting their AUB identification card (ID)

**1.3** The Community Health Nurse at UHS shall follow up on those with abnormal results and on vaccination.

**1.4** TST Screening Test

1.4.1 All new students shall be screened for positive TST (Tuberculin Skin Test) during pre-registration period at the beginning of every semester.

1.4.2 The Community Health Nurse at UHS shall follow up those with a positive TST result.

## 2. *Purpose*

**2.1** To ensure that all new students are in good physical and mental health and are immune against the communicable diseases.

**2.2** To protect the AUB environment and make sure that all new students are healthy and free from contagious diseases.

**2.3** To make sure that the University Health Services has an initial assessment for all the AUB students.

**2.4** To ensure that all students in the medical fields (Medicine, Medical Lab., Nursing, Radiology etc) are immune against Hepatitis B.

## 3. *Procedure*

**3.1** The registrar mails, with the Admission portfolio, an Entrance Student Medical Record (Appendix 5.1) to be completed by the student's personal physician or a physician at Family Medicine clinics by taking a private appointment. HIP does not cover this visit for students.

**3.2** Completed Entrance Medical Record forms are submitted to UHS during pre-registration.

**3.3** The UHS Community Health Nurse does the TST screening through a campaign during the pre-registration period.

**3.4** Two days later, the new students come to UHS for TST reading. Those with positive results will get a chest X-Ray and a doctor's appointment for follow up.

**3.5** New students will be medically cleared and may get their IDs and use the University Health Services for all their health problems.

**3.6** AUB staff dependents may not need to complete this form. An update of their vaccination status will be done at UHS.

**3.7** Medical records of students in the medical field (medical school, Medical Lab, nursing, radiology) should be updated to ensure immunity against the communicable disease, especially Hepatitis B.

**3.8** After the registration period, all medical records are entered on the electronic Health Record-FileMaker, and the community nurse requests list of all newly registered students in order to check for the number of noncompliant students.

## *4. Signatures*

| ***Prepared By*** | ***Name*** | ***Signature*** | ***Date*** |
|---|---|---|---|
| Community Health Nurse | Rita Doudakian | Rita | Aug. 30, 2013 |
| ***Reviewed by*** | ***Name*** | ***Signature*** | ***Date*** |
| Clinic Department Administrator | Mirna Mahfoud Kazan | | Aug 29, 2013 |
| ***Approved By*** | ***Name*** | ***Signature*** | ***Date*** |
| UHS Director | Ghassan Hamadeh, MD | | 5/9/13 |

## *5. Appendix*

**5.1** Student Medical Record

Student ID No. _____

UHS Case No: _____

**CONFIDENTIAL**

**MEDICAL RECORD**

**APPENDIX 5.1**

**AMERICAN UNIVERSITY OF BEIRUT**
**UNIVERSITY HEALTH SERVICES**

Name: _____ _____ _____
(Family) (First) (Father First)

Birth date: _____ Nationality: _____ Gender: ____ Marital status: _____
(Day / month / year)

Home Address: _____ e-mail:_____

Major: _____ Tel: _____

**To the Examining Physician: Thank you** for completing this form which will enable the Health Services to offer better care to prospective students. If you need more space please use a separate form.

## Personal History

***Please check if you have had any of the following:***

- ☐ 1. Eye problems
- ☐ 2. Ear/Nose/Sinus problems
- ☐ 3. Throat/Tonsil infections
- ☐ 4. Infectious mononucleosis
- ☐ 6. Bronchitis
- ☐ 7. Tuberculosis
- ☐ 8. Other lung infections
- ☐ 9. Rheumatic fever
- ☐ 10. Heart murmur
- ☐ 11. Chest pain
- ☐ 12. Rapid heart beat
- ☐ 13. Faint during/after exercise
- ☐ 14. Ulcer (Stomach/Duodenal)
- ☐ 15. High blood pressure
- ☐ 16. Recurrent diarrhea
- ☐ 17. Colitis/enteritis
- ☐ 18. Hepatitis: Type_____
- ☐ 19.Bladder or kidney infection
- ☐ 20. Kidney stone
- ☐ 22. Blood clotting problems
- ☐ 23. Congenital/Birth defects
- ☐ 24. Cancer or malignancy
- ☐ 25. Non-malignant tumor
- ☐ 26. Thyroid disorder
- ☐ 27. Epilepsy or seizures
- ☐ 28. Headache
- ☐ 29. Depression
- ☐ 30. Anxiety
- ☐ 31. Emotional disorder Specify:_____
- ☐ 32. Mental problems Specify:_____
- ☐ 33. Skin problems
- ☐ 34. Measles(Red/Rubeola)
- ☐ 35. Measles(German/Rubella)
- ☐ 36. Mumps
- ☐ 37. Chickenpox
- ☐ 38. Gynecological problem
- ☐ 39. Herpes/ Genital infection
- ☐ 40. Back problem
- ☐ 41. Bone or joint problem
- ☐ 42. Sports-related injury
- ☐ 43. Alcohol or drug use
- ☐ 44. Eating Disorder
- ☐ 45. Learning disability specify_____

## Family History

| | Age | Health Status |
|---|---|---|
| **Father** | | |
| **Mother** | | |
| **Brothers/Sisters** | | |

(If deceased, please list age and cause of death)

Has any of your immediate family ever had any of the following ( please state relationship)

Tuberculosis

Diabetes

Cancer

Heart Disease

High Blood Pressure

Kidney Disease

Other

Other Medical Conditions:

Hospitalizations:

Current Medications:

Allergies:

I hereby certify that the information contained here is complete and correct

_____
Student's signature Date

## PHYSICAL EXAMINATION *(To be completed by your family doctor)*

**Height** _____ **Weight** _____ **BP** _____ **Vision: Right 20/**_____ **Left 20/**_____

| | Normal | Abnormal |
|---|---|---|
| Skin, body marks, scars | | |
| Skeletal system, joints | | |
| Head, neck | | |
| Eyes | | |
| Ear, nose, throat | | |
| Breasts | | |
| Lungs | | |
| Heart | | |
| Abdomen | | |
| Genitalia, hernia | | |
| Neurological | | |

**Abnormal findings**

**Comments/Recommendations**

**Student Immunization Record**

| ***Required Documentation*** | |
|---|---|
| **1- Tetanus – Diphtheria Vaccine**<br>____ Primary series of 3 doses **Date** :<br>____ Td booster within the past 10 years. **Date** :<br>____ Tdap: **Date** : | |
| **2- MMR Vaccine *(Measles, Mumps, Rubella)***<br>Dose1: **Date:**<br>Dose2: **Date:** | **(if not vaccinated, please provide titers)**<br>Measles titer: Pos ____Neg ____ **Date:**<br>Mumps titer: Pos ____Neg ____ **Date:**<br>Rubella titer: Pos ____Neg ____ **Date:** |
| **3- Varicella Vaccine *(Chicken pox)***<br>**Vaccine** Dose1: **Date:**_____<br>Dose2: **Date:**_____<br>History of Varicella *(Chicken pox)*: **Date:**_____<br>*(If not vaccinated please confirm disease or provide titer)* | **(if not vaccinated, please provide titers)**<br>Varicella titer: Pos ____Neg ____ **Date:** |
| **4- Tuberculosis Testing**<br>BCG vaccine if done: **Date**: _____<br>Last TST (previously PPD) ***( within 12 months)***<br>**Date Placed**: __/__/____ **Date Read:** __/__/____<br>Result (*mm indurations*):_____ (*if no indurations record as 0 mm)* | Chest X Ray if TST positive *(please attach copy of the report)*<br>Normal_____ Abnormal_____<br>**Date**:_____<br>***Treatment:***<br>Have you been treated with Anti-tubercular drugs<br>___Yes ___No<br>If Yes, type of treatment_____<br>Length of treatment_____ |
| **5- Meningoccal *(Meningitis)* Vaccine**<br>**(those who plan to live in residence hall/dorms)**<br>**Date:** _____ | |
| ***Recommended Documentation*** | |
| **6 - Hepatitis B Vaccine**<br>Vaccination series:<br>Dose 1: **Date:**_____<br>Dose 2: **Date:** _____<br>Dose 3: **Date:** _____<br>Booster: **Date:** _____ | If not vaccinated,<br>Hepatitis Bs Antigen:<br>Pos ____Neg ____ **Date:**<br>Anti Hepatitis Bs titer if available:<br>Pos ____Neg ____ **Date:** |
| **7- Hepatitis A Vaccine**<br>**Date:** | |
| **8 - Pneumococcal Polysaccharide Vaccine**<br>**Date:** | |
| **9- Other Vaccination** **Date:** | |

Please paste recent photo here

Photo

Physician's Name :_____

Address:_____

e mail : _____

Physician's signature:_____

Date completed:_____

**It is mandatory to return the completed form to the University Health Services (UHS) desk during registration *(in person)***