RHODE ISLAND SCHOOL OF DESIGN

# WELCOME

2 College Street
Providence, Rhode Island 02903
(401) 454-6625 P | (401) 454-6628 F
health@risd.edu

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 June 17th.** All documents must be received by this date.

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

- O Physical Examination Form (Physician signature required)
- O Tuberculosis Test Form (Physician signature required)
- O Vaccination Form with Records (Physician signature required)
- O Student General Information Form

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

Students who have not submitted completed health forms to Health Services will not be able to receive their course schedule and begin attending classes.

This may result in dismissal from their program.

**Please scan and e-mail your forms to: health@risd.edu .**
**Put your "*Last Name, First Name HEALTH FORMS*" in the subject line.**

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

Sincerely,

RISD Health Services

RHODE SLAND SCHOOL OF DESIGN

***To be completed by a Physician, Physician's Assistant, or Nurse Practitioner.***

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DATE OF EXAM: ____/_____/______
MM DD YYYY

## PHYSICAL EXAMINATION

________________________________ ________________ ________ M F M F
Last Name First Name Middle Initial Biological Sex Gender Identity

## ALLERGIES & MEDICATIONS

DOB ___/___/____
MM/DD/YYYY

**List ALL Allergies:**

| MEDICATION | OTHER |
|---|---|
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |
| ________________ | ________________ |

List all prescription & over-the counter medications taken on a regular basis in the past year; including vitamins, oral contraceptives, holistic meds. *Continue on back of form if needed.*

| Medication Name | Dosage | Reason | Presently Taking |
|---|---|---|---|
| ______________ | ______ | __________ | Y N |
| ______________ | ______ | __________ | Y N |
| ______________ | ______ | __________ | Y N |

## 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 | ______________ |
| Lungs | O | O | ______________ |
| Abdomen | O | O | ______________ |
| Musculoskeletal | O | O | ______________ |
| Neurological | O | O | ______________ |
| Psychiatric | O | O | ______________ |

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

Height_______
Weight______

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 | |
| Other: | | | |

**MD Name (PRINT):____________________**
**MD Signature:________________________**
**Address:____________________________**
**Phone:____________________**
**Fax: ____________________**

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 | |

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# Student General Information Form

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health@risd.edu

Last Name____________________ First Name___________________

## PROGRAM (Circle One)

Undergrad | Graduate | Exchange Program | Summer Studies Program | Pre-College Program

## 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 | ____________________ |
| | OR | | |
| 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

RHODE ISLAND SCHOOL OF DESIGN

# Student Immunization Form

***REQUIRED FOR REGISTRATION***

***Not valid without physician signature***

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health@risd.edu


Last Name____________________ First Name___________________

## IMMUNIZATIONS

***PHYSICIAN Complete below & attach copy of immunization record or laboratory titer results***

**TDAP (within last 10 years)**
Date: _____/_____/_______
MM DD YYYY

**OR**

**Td (within last 10 years)**
Date: _____/_____/_______
MM DD YYYY

## MMR

**MMR # 1**
Date: _____/_____/_______
MM DD YYYY

**MMR # 2**
Date: _____/_____/_______
MM DD YYYY

**OR**

**MMR TITER**
Date: _____/_____/_______
MM DD YYYY

Immune: Y N (circle one)

*Attach copy of laboratory titer results.*

## HEPATITIS B

**Hep B # 1**
Date: _____/_____/_______
MM DD YYYY

**Hep B # 2**
Date: _____/_____/_______
MM DD YYYY

**Hep B # 3**
Date: _____/_____/_______
MM DD YYYY

**OR**

**Hep B TITER**
Date: _____/_____/_______
MM DD YYYY

Immune: Y N (circle one)

*Attach copy of laboratory titer results.*

## VARICELLA

**VARICELLA # 1**
Date: _____/_____/_______
MM DD YYYY

**VARICELLA # 2**
Date: _____/_____/_______
MM DD YYYY

**OR**

**ILLNESS**
Date: _____/_____/_______
MM DD YYYY

**OR**

**Varicella TITER**
Date: _____/_____/_______
MM DD YYYY

Immune: Y N (circle one)

*Attach copy of laboratory titer results.*

## MENINGITIS

**MENINGITIS**
Type:__________________
Date: _____/_____/_______
MM DD YYYY

## RECOMMENDED: HEPATITIS A

**HEPATITS A # 1**
Date: _____/_____/_____
MM DD YYY

**HEPATITS A # 2**
Date: _____/_____/_______
MM DD YYYY

**MD Name (PRINT):**____________________
**MD Signature:**_________________________
**Address:**_____________________________
**Phone:**____________________
**Fax:** _____________________

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.

RHODE ISLAND SCHOOL OF DESIGN

**Tuberculosis (TB) Screening**

***Not valid without physician signature***

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health@risd.edu

Last Name____________________ First Name____________________

## TUBERCULOSIS (TB) SCREENING

***PHYSICIAN Complete below / attach copy of chest x-ray or treatment plan if applicable***

________________________________ ____________________ ______________ Date of Birth:______/______/______

Last Name: First Name Middle Initial MM DD YYYY

## TEST RESULTS – SELECT ONE

O No risk factors were identified and the Tuberculin Skin Test was not performed.

OR

O A risk factor has been identified and the Tuberculin Skin Test was performed.

PPD (Mantoux) Placed: ____/____/____
MM DD YYYY

PPD (Mantoux) Read: ____/____/____
MM DD YYYY

Result:_______ (in mm)**

***If 5mm or more, submit copy of chest x-ray or treatment plan*

**MD Name (PRINT):** ________________________
**MD Signature:**____________________________
**Address:**__________________________________
**Phone:**________________________
**Fax:** __________________________

## POSITIVE TUBERCULIN SKIN TEST RESULT

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

**Date of Positive PPD:** ____/____/____
MM DD YYYY

**Chest X-ray:**
*Attach copy of report*
O Normal
O Abnormal
Describe ______________________________
______________________________
______________________________

**Clinical Evaluation:**
O Normal
O Abnormal
Describe: _________________________________
_________________________________
_________________________________

**Medication Treatment Initiated**
O Yes (Drug, Dose, Frequency, Dates Initiated/Completed)
O No (reason)

**MD Name (PRINT):** ________________________
**MD Signature:**____________________________
**Address:**__________________________________
**Phone:**________________________
**Fax:** __________________________

RHODE ISLAND SCHOOL OF DESIGN

**Health Services General Information Form**

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health@risd.edu

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**LOCATION**
Homer Hall (lower Quad)
401-454-6625
M-F 8:30am to 4:30pm
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 and the Administrator on-call will be notified.
If necessary, Public Safety will arrange transportation to an appropriate medical facility and/or arrangements will be made for the student to speak with the counselor on-call.

**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. Students can arrange to have an account set up with a local pharmacy for delivery to Health Services. Students will then be notified when to pick up their medications. For more information, please refer to the ***Pharmacies in Providence*** document on our website at www.risd.edu/Students/W ellness/Health_Services/.

**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.