From the Health Services Office

Welcome to Moore College of Art & Design. Health Services is located on the first floor of Stahl Hall. Diane Azuma, Moore's Registered Nurse, is available during the fall and spring semesters to meet students' routine health care needs and to handle emergencies. Health Services is open Monday through Friday from 9am-3pm.

Counseling Services

In addition to your coverage for your physical needs, Student Affairs also has two mental health counselors: Andrea Bernstein and Joe Coppola. The counselor hours are Monday – Friday, 11am – 7 pm. The counselors also make referrals to off-campus therapists or psychiatrists and handle psychological emergencies in conjunction with other relevant staff members or administration.

Health Insurance

Moore requires that all undergraduate students have health insurance. If you are insured under your family's health plan, you will need to submit documentation of coverage. The link to the health insurance waiver will be made available via Moodle on the New Student Guide. For students without coverage, you will need to purchase Moore's insurance. Note, if you do not fill out the waiver or opt-out form, you will be automatically enrolled in Moore's insurance. Unfortunately, at this time, Graduate students are not eligible for Moore's Health Insurance plan.

Health Form

Enclosed in this letter is the health form. It is your responsibility to have this form completed, signed by your physician, and returned to the health services office. You must see a doctor in order to fill out sections of this form, so make sure to make an appointment as soon as possible. It can sometimes take several weeks or even a month to get an appointment.

What you need to include with the Health Form

In order to ensure that each section is thoroughly completed, you will find a checklist in the packet that outlines which sections you and your doctor must fill out. You must also include the following and attach it to this form:

-Your immunization record
-a copy (front and back) of your health insurance card

Due Dates

It is very important that you complete the health form and have it sent in by the dates listed below. The due date is contingent upon whether you live on or off campus. Failure to return a completed health form will result in a $100 penalty, and a hold will be placed on your student account.

THIS FORM IS DUE: Sunday, August 1, 2021 (Incoming Residents) Residents without completed health forms may not move into housing.
THIS FORM IS DUE: Sunday, September 26, 2021 (Commuter Students)

Finding a Physician

If you do not have a primary care doctor and need guidance, you may contact the Student Services Office (215-965-4040) and we can assist you in figuring out the steps to finding a doctor's office or clinic. All charges for your office visit are your responsibility. There is typically a fee for a visit, in addition to the charge for vaccinations or laboratory work you may require. You must bring previous vaccination records to the physician as well.

We are pleased to say that the college is well equipped to meet your health needs. There are no long waits or anonymity often associated with university health services. We welcome you as an incoming student and look forward to helping you stay healthy while you pursue your education as an artist.

Sincerely,
Diane Azuma
Director of Health Services
Tel: 215-965-4032
Fax: 215-564-1459

Health History and Immunization Form Checklist

Use this form as a checklist to make sure every section of this form is completed by you and your Health Care Provider. There are five sections of the form.

❑ **A. Section I: Health History—to be completed by the Student.**

This information is strictly for the use by Health Services Staff and will not be released to anyone. **All students must sign the bottom of Section I, verifying that the information is correct.**

*Note, if you are under the age of 18, your parent or guardian must sign directly below in the section labeled "Parental Permit."

❑ **B. Section II: List of Required vaccines and Recommended vaccines**

Please read through the listed vaccines. Your doctor will be required to fill out and verify in the next section. Also discuss with your health care provider the need for the additional four vaccines indicated on the bottom of the page.

❑ **C. Section III: Immunization Record—to be completed by a physician**

In addition to attaching an official copy of your immunization record, your physician must complete this section of the form. If you do not have a required vaccine, the record indicates the next steps your physician must take.

❑ **D. Section IV: Tuberculosis Screening—to be completed by you AND the Physician**

Your doctor should read over this section and circle either yes or no for each bullet point. If you circle yes to any of the questions, your doctor must conduct a Tuberculin skin Test.

❑ **E. Section V: Tuberculosis Risk Assessment—to be completed by physician.**

If it is determined that you must receive a TB Skin Test, as indicated in Section IV, your doctor must go through the steps of filling out this form. The results of this test take several days to read; therefore you will need to bring back this section of the form when you return to the office for the results in order for this form to be completed.

❑ **F. Additional Reminders**

1. Make sure your Health Care Provider Signs and dates the form on page 7. It will not be complete until she/he does so.
2. Do not forget to attach a copy of your current insurance plan as well as a copy of your immunization record.
3. Instructions for returning the form are provided on page 7.

START DATE: _____ ❑ Undergraduate ❑ SADI ❑ Graduate ❑ Post Bacc.

SECTION I: TO BE FILLED OUT BY THE STUDENT

A health history must be completed by **ALL** students. This information is strictly for the use of the Student Health Services and will not be released to anyone without your knowledge or consent. **PLEASE COMPLETE AND RETURN DIRECTLY TO THE DIRECTOR OF HEALTH SERVICES.**

Last name _____ First _____ Middle _____ Moore Student ID number _____

Home address _____ City _____ State _____ Zip _____

Local address _____ City _____ State _____ Zip _____

Date of Birth _____ Marital Status _____ Class Entering _____ Home Telephone _____ Cell phone # _____

Emergency Contact Person _____ Home Telephone _____ Business Telephone _____

HEALTH INSURANCE INFORMATION: PLEASE ATTACH A COPY OF THE FRONT AND BACK OF YOUR HEALTH INSURANCE CARDS

PERSONAL HISTORY: Please answer all questions

Gastrointestinal:	**Yes**	**No**
Constipation	❑	❑
Recurrent diarrhea	❑	❑
Hemorroids	❑	❑
Ulcer	❑	❑
Frequent upset stomach	❑	❑
Heartburn	❑	❑
Irritable bowel	❑	❑
Jaundice	❑	❑
Gall bladder problem	❑	❑
Hernia	❑	❑
Other:	❑	❑

Genitourinary:	**Yes**	**No**
Kidney disease	❑	❑
Bladder/kidney infections	❑	❑
Kidney stones	❑	❑
Sexually transmitted infection	❑	❑
No period	❑	❑
Painful periods	❑	❑
Irregular periods	❑	❑
Breast lump	❑	❑
Pelvic infection	❑	❑
Pregnancies	❑	❑
Other:	❑	❑

Musculoskeletal:	**Yes**	**No**
Back problems	❑	❑
Arthritis	❑	❑
Strains/sprains	❑	❑
Neck injury	❑	❑
Other:	❑	❑

Skin:	**Yes**	**No**
Acne	❑	❑
Eczema	❑	❑
Psoriasis	❑	❑
Rashes	❑	❑
Other:	❑	❑

Head:	**Yes**	**No**
Eye problems	❑	❑
Glasses/Contacts	❑	❑
Ear infections	❑	❑
Hearing difficulty	❑	❑
Nose problems	❑	❑
Sinusitis	❑	❑
Throat problem	❑	❑
Other:	❑	❑

Cardiovascular:	**Yes**	**No**
Murmur	❑	❑
High or low blood pressure	❑	❑
Anemia	❑	❑
Antibiotics prior to dental work	❑	❑
Palpitations	❑	❑
Chest pain	❑	❑
Blood clots	❑	❑
High cholesterol	❑	❑
Other:	❑	❑

Respiratory:	**Yes**	**No**
Asthma	❑	❑
Bronchitis	❑	❑
Pneumonia	❑	❑
Tuberculosis	❑	❑
Chronic cough	❑	❑
Shortness of breath	❑	❑
Other:	❑	❑

Neurological:	**Yes**	**No**
Headache	❑	❑
Dizziness/fainting	❑	❑
Seizures	❑	❑
Weakness	❑	❑
Head injury/concussion	❑	❑
Paralysis	❑	❑
Loss of consciousness	❑	❑
Frequent anxiety	❑	❑
Frequent depression	❑	❑
Worry/nervousness	❑	❑
Other:	❑	❑

Metabolic/Endocrine:	**Yes**	**No**
Diabetes	❑	❑
Thyroid disorder	❑	❑
Other	❑	❑

Other:	**Yes**	**No**
Cancer	❑	❑
Anorexia / bulimia	❑	❑
Radiation/ chemotheraphy	❑	❑
Recent weight gain/loss	❑	❑
Do you drink alcohol?	❑	❑
Do you smoke?	❑	❑

Infectious Illnesses:	**Yes**	**No**
Chicken pox	❑	❑
Measles	❑	❑
Rubella-German measles	❑	❑
Mumps	❑	❑
Mononucleosis	❑	❑
Hepatitis Type:	❑	❑
Rheumatic fever	❑	❑
Other:	❑	❑

Last Name _____ First Name _____ DOB: _____ / _____ / _____

Do you take any medications? (ie: all drugs, including over the counter drugs, birth control pills, laxatives, sleeping medications, etc.) **Yes**_____ **No**_____

If yes, please list: _____

Please list Physician(s), Dentist, Opthamologist	**Telephone number**

	Yes	**No**	**If yes, please give details**
Are you allergic to any medications?	❑	❑	
Allergies (Food, insects, others)	❑	❑	
Have you had difficulty with school studies or teachers?	❑	❑	
Have you had an illness or injury or been hospitalized other than already noted?	❑	❑	
Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problem?	❑	❑	

FAMILY HISTORY

Parents	**Age**	**State of Health**	**Occupation**	**Age of Death**	**Cause of Death**

TO BE SIGNED BY THE STUDENT (MUST BE SIGNED BY STUDENT OR FORM WILL NOT BE PROCESSED)

1. STUDENT STATEMENT

ALL STUDENTS: The information provided in this form is correct. I understand that failure to complete the form correctly may jeopardize my student standing at Moore College of Art & Design. I will return the form to the appropriate address at the end of this form.

Student Signature_____

Student ID #:

___ ___ ___ ___ ___ ___ ___ ___ ___

Signature of parent/guardian if student is a minor_____ _____Date_____

PARENTAL PERMIT

The Law requires that parental permission be obtained for procedures on minors. The following consent form should be signed by the parents so that such procedures may be promptly carried out with no unnecessary delays. However, no major operation will be performed, except in extreme emergency, without parents being contacted and fully informed. I give permission for such diagnostic and therapeutic procedure as may be deemed necessary for my daughter and also to present information concerning her medical condition to other responsible college officials when deemed desirable.

Signature_____Relationship_____Date_____

SECTION II: List of Immunization Requirements

As a condition of enrollment, all full-time students and all students living in campus housing must meet the following requirements. Failure to meet these requirements will result in denial of student registration privileges.

1. Hepatitis B

Hepatitis B, recombinant (Engerix-B, Recombivax HB)
Hepatitis B recombinant, adjuvanted HepB-CpG (Heplisav-B)

• Hep B—series of 3 doses (given at 0, 1 and 6 mo. interval) for adults 18 and over; adolescents ages 11-15 years may receive 2 adult doses of Recombivax HB (given at 0 and 4-6 mo. interval) *

• Adjuvanted HepB-CpG—series of 2 doses (given at 0, 1 mo.); age 18 or older who are unvaccinated or incompletely vaccinated; must have minimum of 4 weeks interval and both doses HepB-CpG

• Blood test showing immunity

INTERCHANGEABILITY AND DOSING SCHEDULE:
Series consisting of a combination of 1 dose of adjuvanted HepB-CpG and Hep B):

• Adhere to the 3-dose schedule, minimum of 4 weeks between dose 1 & 2; 8 weeks between dose 2 & 3; and 16 weeks between dose 1 & 3.

• If HepB-CpG is substituted for dose 2 of Hep B, it is recommended that the HepB-CpG is the third dose (given a minimum of 4 weeks from the previous dose to complete the 3-dose series). **Combined hepatitis A and B vaccines may be given as a series of 3 doses (given at 0, 1-2, and 6-12 mo.) for 18 years of age and older.*

2. Measles, Mumps, Rubella (MMR)

• 2 doses of MMR vaccine are required. Dose 1 must be administered after the 1st birthday. Dose 2 must be administered at least 4 weeks after the 1st dose. OR
• Blood test showing immunity

3. Varicella (Chicken Pox)

• 2 doses of varicella (chicken pox) vaccine are required. They must be administered at least 4 weeks apart. OR
• Blood test showing immunity OR
• Physician documented history of chicken pox disease

4. Tetanus-Diphtheria-Pertussis (Tdap)

• 1 dose of Tdap (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis) vaccine is required, and must be dated 2005 or later.
• Td (tetanus-diphtheria) vaccine does not satisfy this requirement.
• Td vaccine booster is also required if Tdap is older than 10 years.

5. Meningococcal

• 1 dose of meningococcal conjugate vaccine (MCV4, such as Menactra or Menveo) administered since age 16 is required of all incoming students who are age 21 or younger.
    o Meningococcal conjugate vaccine is preferred although meningococcal polysaccharide vaccine (MPSV4, such as Menomune) is acceptable.
    o At minimum, serogroups A, C, Y, and W-135 must be covered.
• Incoming students living on campus who are age 22 or older may submit either proof of vaccination or a Meningococcal Vaccine Waiver.
• www.cdc.gov/meningococcal

6. Tuberculosis

• Screening and risk assessment required. Please discuss with healthcare provider.

SECTION II: List of Immunization Requirements

As a condition of enrollment, all full-time students and all students living in campus housing must meet the following requirements. Failure to meet these requirements will result in denial of student registration privileges.

Please discuss the need for the following vaccines with your healthcare provider.

7. Influenza

- Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

8. Quadrivalent Human Papillomavirus Vaccine (HPV2, HPV4 or HPV9)

(Three doses of vaccine for females and male 11-26 years of age at 0, 2, and 6 month intervals.)

9. Pneumococcal Polysaccharide Vaccine

(One dose for members of high-risk groups)

10. Meningococcal Serougroup B

(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)

SECTION III: IMMUNIZATION RECORD

THIS FORM IS DUE **Sunday, August 1, 2021** (Incoming Residents)
THIS FORM IS DUE **Sunday, September 26, 2021** (Commuter Students)

PART 1: COMPLETED BY THE STUDENT.
ALL INFORMATION MUST BE PRINTED LEGIBLY OR FORM CANNOT BE PROCESSED.

Last Name: _____ First Name: _____ Middle Initial: _____

DOB: _____ / _____ / _____ Date of Entry: _____ / _____ / _____ Student ID #: ___ ___ ___ ___ ___ ___ ___ ___ ___

Full Mailing Address:
Street Address _____ City _____ State _____ ZIP Code _____

Please Check: ___ Resident ___ Commuter Please Check: ___ Undergraduate ___ Graduate ___ SADI ___ Post Bacc.

PART 2: TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER.

Hepatitis B
Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3
Adult Formulation _____ Child Formulation _____HepB-CpG (Heplisav-B)_____
AdultFormulation _____ Child Formulation _____HepB-CpG (Heplisav-B)____

2. Immunization (Combined hepatitis A and B vaccine)
a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

3. Quantitative Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country, and/or men who have sex with men).
Date ____/____/_____ Result: Reactive _____ Non-reactive _____

Dose 1 ___/__/___ Month Day Year
Dose 2 ___/__/___ Month Day Year
Dose 3 ___/__/___ Month Day Year

Measles, Mumps, Rubella
2 doses of vaccine or a blood test showing immunity.

Measles Antibody month _____ yr. ____
result: positive_____ negative_____
Mumps Antibody month _____ yr____
result: positive_____negative_____
Rubella Antibody month _____ yr____
result: positive_____negative_____

MMR Dose 1 ___/__/___ Month Day Year
MMR Dose 2 ___/__/___ Month Day Year

OR

Measles Dose 1 ___/__/___ Month Day Year
Measles Dose 2 ___/__/___ Month Day Year
Mumps Dose 1 ___/__/___ Month Day Year
Mumps Dose 2 ___/__/___ Month Day Year
Rubella Dose 1 ___/__/___ Month Day Year
Rubella Dose 2 ___/__/___ Month Day Year

Meningococcal (serogroups A, C, Y, and W-135)
1 dose since age 16 for all incoming students who are age 21 or younger.

Meningococcal Last Dose ___/__/___ Month Day Year
Please specify vaccine type: _____
(such as Menactra, Mencevax, Menomune, Menveo, and ACYW-135) **or Serogroupscovered:**_____

Tetanus-Diphtheria and Pertussis (Tdap)
Incoming students must have proof of Tdap immunization dated 2005 or later.
Td (tetanus- diphtheria) does not satisfy this requirement.
Td vaccine booster is also required if Tdap is older than 10 years.

Tdap ___/__/___ Month Day Year
Td ___/__/___ Month Day Year

Varicella (Chicken Pox)
2 doses of vaccine ***or*** history of illness, ***or*** a blood test showing immunity.

Dose 1 ___/__/___ Month Day Year
Dose 2 ___/__/___ Month Day Year
OR
Varicella Illness ___/__/___ Month Day Year

Varicella antibody month _____ yr. ____
result: positive_____negative_____

Other:

Section IV: To be completed by Student and Physician.

Last Name _____ **First Name** _____ **DOB** _____

TUBERCULOSIS (TB) SCREENING/TESTING

Please answer the following questions:

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

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

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
Eswatini
Ethiopia
Fiji
French Polynesia
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
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
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
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
United Republic of Thailand
Timor-Leste
Togo
Tokelau
Trinidad & Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/

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

4. 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

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

6. 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, Moore College of Art & Design 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 required.

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

SECTION V: Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes_____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes_____ No _____

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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:

- ❑ 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

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)
(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given:____/____/____ (M D Y) Date Read:____/____/____ (M D Y)

Result:_____mm of induration **Interpretation: positive____negative_____

Date Given:____/____/____ (M D Y) Date Read:____/____/____ (M D Y)

Result:_____mm of induration **Interpretation: positive____negative_____

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight. .

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

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

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal____
M D Y

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with M. tuberculosis (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

_____Student agrees to receive treatment

_____Student declines treatment at this time

_____ _____
Health Care Professional Signature Date

Completed Forms and Copies of Health Insurance Cards can be scanned and uploaded online via your Student Portal in a single PDF.

Moore College of Art & Design Health Services Office
1916 Race Street and The Parkway Philadelphia, PA 19103
215.965.4032 | 215.564.1459 (fax)
healthservices@moore.edu