SUMMER ART & DESIGN INSTITUTE (SADI)
HEALTH FORM

THIS PACKET IS DUE PRIOR TO MONDAY, JUNE 1, 2026

Scan and email your completed packet to the healthservices@moore.edu
with student's FULL NAME in the subject line.

Failure to complete ALL sections will result in inability to reside in Moore's dorms.

Use this form as a checklist to ensure every section of this form is completed by you and your health care provider.

☐ Section I: Health History – completed by the Student

This information is strictly for use by Health Services and will not be released to anyone. All students must sign when prompted in Section I, verifying 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/Guardian Permit'.

☐ Section IA: Treatment Consent Form – completed by a Guardian

All Parents/Guardians must sign a treatment consent form to ensure their student can receive urgent care treatment over the duration of the program, if necessary.

☐ Section II: Student Physical – completed by a Health Care Provider

In addition to attaching an official copy of your immunization record, your Health Care Provider **must** complete the indicated sections of the form. Additionally, we must have documentation of required vaccines.

☐ Section III: Immunizations – completed by a Guardian AND/OR Health Care Provider

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.

☐ Section IV: Tuberculosis Screening – completed by a Guardian AND/OR Health Care Provider

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.

Additional Reminders

- Parents/Guardians: when submitting your completed packet to healthservices@moore.edu, **please put your student's FULL NAME in the subject line of the email.**
- Parents/Guardians: please complete the consent form on page 5.
- Make sure your health care provider signs and dates the form on page 6. It will not be complete until they do.
- Do not forget to attach a copy of your current insurance card. Please ensure this copy is a PDF's.
- Please upload documents as PDFs. **We cannot accept, process, or print photos** (.jpgs, .heics, or .pngs). If you are unsure how to scan and send a document, please follow the instructions at the end of this document. **The instruction page does not need to be included in the final upload.**

HOW TO SCAN AND SEND DOCUMENTS

A Note from Health Services: When submitting your health forms, **please be sure to upload them as scanned documents (PDF format only!)**. Unfortunately, we are unable to accept or print photos taken on phones (.jpgs, .pngs, .heics), as our system cannot process these file types.

If you need help scanning your forms, please follow the instructions below. Thank you in advance for your cooperation.

If you have any questions or run into any issues, please reach out to the Health Services office at healthservices@moore.edu.

Scanning and sending a document using an iPhone:

1. **Open the Notes App**: Launch the notes app on your iPhone.
2. **Start a New Note:** Tap the compose icon in the lower right corner to start a new note.
3. **Initiate Scanning:** Tap the paperclip or camera icon within the note and select "Scan Documents".
4. **Scan the Document:** Position your iPhone camera over the document. If in Auto mode, the app will automatically scan the page. If in "Manual" mode, tap the shutter button on screen or click a volume button to scan manually.
5. **Save the Scan:** Tap "Save" after each scan. You can scan multiple pages in one session.
6. **Adjust the Scan (Optional):** After capturing the image(s), you can adjust the scan. You can crop, rotate, or change the color scheme.
7. **Share the Document:** Tap on the scanned document in the note. Tap the share icon (the box with an arrow) and select "Mail".
8. **Compose and Send:** Compose your email, address it, and send it off.

**The document can also be saved to Files or the iCloud Drive for alternate access on linked devices.*

Scanning and sending a document using an Android phone:

1. **Open Google Drive and Scan**: Launch the Google Drive app on your phone. Tap the "+" button (usually in the bottom right corner) and choose "Scan".
2. **Capture the Document:** Position your phone's cam,era over the document you want to scan. The app may automatically detect and capture the document, or you can manually capture it.
3. **Adjust the Scan (Optional):** After capturing the image(s), you can adjust the scan. You can crop, rotate, or change the color scheme.
4. **Save and Share:** Once you're satisfied with the scan, tap "Save". You can then choose a name for the file and select the location in Google Drive where you want to save it. To share the scanned document, you can open it in Google Drive and use the share option to send it via email.

PROGRAM TYPE: ☐ Undergraduate ☐ Graduate ☐ SADI

SECTION I: HEALTH HISTORY

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE STUDENT.

STUDENT INFORMATION

Legal Last Name	Legal First Name	Middle Initial	Preferred Name (if applicable)

Home Address	City	State	ZIP Code

Date of Birth (MM/DD/YYYY)	Assigned Sex at Birth	Gender Identity	Pronouns

Home Phone	Student Cell Phone	Student Email

Emergency Contact Name	Relationship	Emergency Contact Cell Phone

Will you be living in a residence hall on campus? ☐ YES ☐ NO

HEALTH INSURANCE INFORMATION

Name of Insurance Company	Type of Plan (PMO, HMO)

Insurance ID Number	Group Number

Insurance Company's Phone Number	Subscriber's Full Name

Subscriber's Date of Birth	Student's Relationship to Subscriber

FAMILY BACKGROUND

	Age	State of Health	Occupation	Age of Death (if applicable)	Cause of Death (if applicable)
Parent/Guardian					
Parent/Guardian					

NAME: _____ MOORE ID: _____

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE STUDENT.

MEDICAL HISTORY

Please provide a brief explanation in the comments section below if marking yes on any of the following.

Gastrointestinal	YES	NO
Reflux/GERD		
Frequent Upset Stomach		
Irritable Bowel		
Other		

Genitourinary	YES	NO
Kidney Disease		
Bladder/Kidney Infections		
Painful Periods		
Irregular Periods		
No Periods		
STIs		
Other		

Head	YES	NO
Eye Condition		
Glasses/Contacts		
Hearing Loss/Difficulty		
ENT Condition		
Concussion History		
Other		

Endocrine	YES	NO
Diabetes		
Thyroid Disorder		
Other		

Skin	YES	NO
Acne		
Eczema		
Other		

Musculoskeletal	YES	NO
Back Problems		
Arthritis		
Strains/Sprains		
Fracture History		
Neck Injury		
Other		

Neurological	YES	NO
Frequent Headaches		
Dizziness/Fainting		
Seizure Disorder		
Head Injury/Concussion		
Other		

Other
Please indicate if not noted above.
Other:

Cardiovascular	YES	NO
High or Low Blood Pressure		
Anemia		
Arrhythmia		
Blood Clot History		
Other		

Respiratory	YES	NO
Asthma		
Pneumonia		
Chronic Cough		
Shortness of Breath		
Other		

Mental Health	YES	NO
Eating Disorder		
OCD		
Bipolar Disorder		
Anxiety/Depression		
Autism		
ADD/ADHD		
Other		

List any medications you take on a regular basis. Include prescriptions, OTCs, birth control, and dietary supplements.

_____

_____

Comments/Additional Info:

_____

_____

_____

_____

NAME: _____ MOORE ID: _____

SECTION I: HEALTH HISTORY

THE FOLLOWING INFORMATION IS TO BE COMPLETED BY THE STUDENT.

ALLERGY INFORMATION

Do you have any allergies? ☐ YES ☐ NO Do you carry an EpiPen? ☐ YES ☐ NO

If yes, list all allergies (including food, medicines, etc)

_____

_____

HEALTH CARE PROVIDER CONTACTS

Please list Physician(s), Dentist, Ophthalmologist, or any other relevant healthcare providers.

Telephone Numbers

_____ _____

_____ _____

_____ _____

_____ _____

SIGNATURES

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

ALL STUDENTS: I understand that I must complete this truthfully and to the best of my ability. I understand that failure to complete this form correctly may jeopardize my student standing at Moore College of Art & Design. I will return the form through the method that has been specified to me.

Student Signature: _____ Date: _____

Signature of parent/guardian if student is a minor: _____ Date: _____

PARENTAL/GUARDIAN 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 procedures may be deemed necessary for my child and to present information concerning their medical condition to other responsible college officials when deemed desirable.

Signature: _____ Relationship: _____ Date: _____

Consent to Treat – Non-Parent/Guardian to Accompany Patient

This authorization gives below named person(s) permission to bring your child(ren) in, speak to the doctor, authorize the child(ren) for treatment, vaccinations, medications, certain procedures and to make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Vybe Urgent Care, Jefferson Urgent Care, or any other applicable urgent care location, and discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider.

I also give them authority to make more serious or urgent health care decisions in the event that I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ D.O.B: _____

Child's Name: _____ D.O.B: _____

Child's Name: _____ D.O.B: _____

I permit the SADI Program Staff to take my child to Vybe Urgent Care or Jefferson Urgent Care in the event of medical necessity.

(Please note: if you select 'no', you will be required to transport and accompany your child to the Urgent Care visits at your earliest convenience.)

☐ YES

☐ NO

Printed Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____

Date: _____

***This form must be accompanied by a photo copy of the parent or guardian's Photo ID.**

NAME: _____ D.O.B:_____

SECTION II: STUDENT PHYSICAL

THE FOLLOWING INFORMATION IS TO BE COMEPLETED BY A HEALTHCARE PROVIDER

PHYSICAL ASSESSMENT

Date of examination: BP: / Pulse: Height:_____ in Weight:_____ lbs

Medication Allergies: _____

Current Medications: _____

	NORMAL	ABNORMAL	COMMENTS
Skin			
Ears, Eyes, Nose, Throat			
Mouth, Teeth, Gums			
Endocrine			
Respiratory			
Cardiac			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurological			
Emotional/Psychological			
Other			

Additional Comments: _____

This student is able to meet the physical and emotional demands of college life: ☐ YES ☐ NO*

*Please provide an explanation if selecting no: _____

HEALTH CARE PROVIDER INFORMATION

Provider's Name (printed): _____ Telephone: _____

Address: _____ Fax: _____

Provider Signature and Date: _____ **Provider's Stamp:** _____

NAME: _____ D.O.B:_____

SECTION III: IMMUNIZATIONS

THE FOLLOWING INFORMATION IS TO BE COMEPLETED BY A HEALTHCARE PROVIDER

REQUIRED IMMUNIZATIONS

Measles, Mumps, Rubella							
Two doses of vaccine or a blood test showing immunity.							
Measles Antibody	month _____ year_____ result: positive (yes) or (no)	*OR*	MMR Dose 1 ___/___/____ MM/DD/YYYY MMR Dose 2 ___/___/____ MM/DD/YYYY	*OR*	Measles Dose 1 ___/___/____ MM/DD/YYYY	Mumps Dose 1 ___/___/____ MM/DD/YYYY	Rubella Dose 1 ___/___/____ MM/DD/YYYY
Mumps Antibody	month _____ year_____ result: positive (yes) or (no)				Measles Dose 2 ___/___/____ MM/DD/YYYY	Mumps Dose 2 ___/___/____ MM/DD/YYYY	Rubella Dose 2 ___/___/____ MM/DD/YYYY
Rubella Antibody	month _____ year_____ result: positive (yes) or (no)						

Meningococcal*	Meningococcal Dose 1	Meningococcal Dose 2	Please specify vaccine type (or serogroups): (Menactra, Menevo, Mencevax, etc)
*(serogroups A, C, Y, and W-135) Two doses of the vaccine. **Note: Students must have received a dose on or after the age of 16 to be considered fully immunized.**	___/___/____ MM/DD/YYYY	___/___/____ MM/DD/YYYY	_____ _____ _____

Polio		Dose 1	Dose 2	Dose 3
OPV Alone (Oral Sabin, three doses)		___/___/____ MM/DD/YYYY	___/___/____ MM/DD/YYYY	___/___/____ MM/DD/YYYY
IPV/OPV Sequential	IPV 1 ___/___/____ MM/DD/YYYY	IPV 2 ___/___/____ MM/DD/YYYY	OPV 1 ___/___/____ MM/DD/YYYY	OPV 2 ___/___/____ MM/DD/YYYY

Varicella (Chicken Pox)					
Two doses of vaccine ***or*** a history of illness ***or*** a blood test showing immunity.		Varicella Dose 1 ___/___/____ MM/DD/YYYY	Varicella Dose 2 ___/___/____ MM/DD/YYYY	*OR*	Varicella Illness ___/___/____ MM/DD/YYYY
Varicella Antibody	month _____ year_____ result: positive (yes) or (no)				

Hepatitis B			
Three doses of vaccine ***or*** a blood test showing immunity.	Hepatitis Dose 1 ___/___/____ MM/DD/YYYY	Hepatitis Dose 2 ___/___/____ MM/DD/YYYY	Hepatitis Dose 3 ___/___/____ MM/DD/YYYY
Hepatitis B Surface Antibody month _____ day _____year_____ result: reactive _____ non-reactive _____			

Tetanus-Diphtheria & Pertussis			
(Tdap) Td alone does not satisfy this requirement.	Tdap ___/___/____ MM/DD/YYYY	Td (booster) ___/___/____ MM/DD/YYYY	Td booster is required if Tdap booster is older than 10 years.

NAME: _____ D.O.B:_____

THE FOLLOWING INFORMATION IS TO BE COMEPLETED BY A HEALTHCARE PROVIDER

RECOMMENDED IMMUNIZATIONS

Meningococal* *(serogroup B) Two doses of the vaccine. **Note: Students must have received a dose on or after the age of 16 to be considered fully immunized.**	MenB-RC Dose 1 ___/___/____ MM/DD/YYYY MenB-RC Dose 2 ___/___/____ MM/DD/YYYY	*OR*	MenB-FHbp Dose 1 ___/___/____ MM/DD/YYYY	MenB-FHbp Dose 2 ___/___/____ MM/DD/YYYY	MenB-FHbp Dose 3 ___/___/____ MM/DD/YYYY

HPV (Human Papillomavirus) ☐ HPV4 ☐ HPV9	HPV Dose 1 ___/___/____ MM/DD/YYYY	HPV Dose 2 ___/___/____ MM/DD/YYYY	HPV Dose 3 ___/___/____ MM/DD/YYYY

SARS-CoV-2 (Novel Coronavirus)	Dose 1 ___/___/____ MM/DD/YYYY Manufacturer _____	Dose 2 ___/___/____ MM/DD/YYYY Manufacturer _____	Dose 3 (Booster Dose) ___/___/____ MM/DD/YYYY Manufacturer _____

Influenza	Administered on ___/___/____ MM/DD/YYYY	Lot # _____	Expiration Date ___/___/____ MM/DD/YYYY
	Manufacturer:_____		

Other List Vaccine Name:	Dose 1 ___/___/____ MM/DD/YYYY	Dose 2 ___/___/____ MM/DD/YYYY	Dose 3 ___/___/____ MM/DD/YYYY

Other List Vaccine Name:	Dose 1 ___/___/____ MM/DD/YYYY	Dose 2 ___/___/____ MM/DD/YYYY	Dose 3 ___/___/____ MM/DD/YYYY

NAME: _____ D.O.B:_____

SECTION IV: TUBERCULOSIS SCREENING

THE FOLLOWING INFORMATION IS TO BE COMEPLETED BY YOU AND A HEALTHCARE PROVIDER

I. SCREENING QUESTIONNAIRE (COMPLETED BY STUDENT)

1. Have you ever had close contact with persons known or suspected to have active TB disease? ☐ YES ☐ NO
2. Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America, Eastern Europe? ☐ YES ☐ NO

If yes, what country/countries? _____ How long?_____

3. Have you been a resident and/or employee of high-risk congregate settings (correctional facilities, long-term care facilities, and homeless shelters)? ☐ YES ☐ NO
4. Have you been a volunteer/healthcare worker who served clients who are at an increased risk for active TB? ☐ YES ☐ NO
5. Have you 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 under served, low-income, or those abusing drugs or alcohol? ☐ YES ☐ NO

If the answer is NO to all of the above, no further action is needed.

If the answer is YES to any of the above, Moore requires that you receive TB testing via Interferon Gamma Release Assay (IGRA) blood work within six months of college entrance. TTS/skin testing is not acceptable and TB blood testing is required regardless of BCG status. In addition, your health care provider needs to complete the following parts.

II. CLINICAL ASSESSMENT BY HEALTH CARE PROVIDER

Does the patient have a history of a positive TB skin test or IGRA blood test? ☐ YES ☐ NO

(if YES, provide documentation of testing/chest x-ray treatment with dates)

Does the patient have a history of a receiving the BCG vaccine? ☐ YES ☐ NO

Does the patient have signs of active TB such as cough lasting longer than 3 weeks, coughing up blood, chest pain, loss of appetite, unexplained weight loss, night sweats, or fever? ☐ YES ☐ NO

(if YES, proceed with additional evaluation to exclude active TB disease)

TB testing completed via Interferon Gamma Release Array (IGRA) (please circle one)

Test done: QFT-GIT/T-Spot Date Obtained: __/__/_____

Result: Negative __ Positive __ Indeterminate __ (repeat testing required if result is indeterminate)

Test done: QFT-GIT/T-Spot Date Obtained: __/__/_____

Result: Negative __ Positive __ Indeterminate __

Tuberculin Skin Test (TST)

Date Given: __/__/_____ Result: __ mm of induration

Date Read: __/__/_____ Interpretation:

Positive __ Negative __

Date Given: __/__/_____ Result: __ mm of induration

Date Read: __/__/_____ Interpretation:

Positive __ Negative __

Chest x-ray REQUIRED with positive IGRA

Date of chest x-ray: __/__/_____ Result: Normal ___ Abnormal ___

NAME: _____ D.O.B:_____

SECTION IV: TUBERCULOSIS SCREENING

THE FOLLOWING INFORMATION IS TO BE COMEPLETED BY A HEALTHCARE PROVIDER

III. MANAGEMENT OF POSITIVE IGRA

All students with a positive 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 LBTI to TB disease and should be prioritized to begin treatment as soon as possible.

Check increased risk group below if applicable:

- ☐ 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 immunosuppresive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15mg of prednisone per day, or immunosuppresive 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

SELECT ONE:

___ Student agrees to receive treatment, please provide documentation of therapy and dates of treatment

___ Student declines treatment at this time and understands the risks associated with declining treatment

___ Not applicable; This student does not need treatment at this time

IV. HEALTH CARE PROVIDER ATTESTATION

I have reviewed the information included in this questionnaire with the patient, their individual risk for infection, as well as signs and symptoms of an active TB infection and when this student should seek care.

Health Care Provider Signature: _____ Date: _____