

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



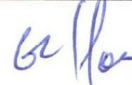
- 2.1 To ensure that all new students are in good physical and mental health and are immune against the communicable diseases.
- 2.2 To protect the AUB environment and make sure that all new students are healthy and free from contagious diseases.
- 2.3 To make sure that the University Health Services 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		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: _____

CONFIDENTIAL

APPENDIX 5.1

UHS Case No: _____

MEDICAL RECORD

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		Family History	
<i>Please check if you have had any of the following:</i>		Age	Health Status
<input type="checkbox"/> 1. Eye problems	<input type="checkbox"/> 24. Cancer or malignancy	Father	
<input type="checkbox"/> 2. Ear/Nose/Sinus problems	<input type="checkbox"/> 25. Non-malignant tumor	Mother	
<input type="checkbox"/> 3. Throat/Tonsil infections	<input type="checkbox"/> 26. Thyroid disorder	Brothers/Sisters	
<input type="checkbox"/> 4. Infectious mononucleosis	<input type="checkbox"/> 27. Epilepsy or seizures	(If deceased, please list age and cause of death)	
<input type="checkbox"/> 6. Bronchitis	<input type="checkbox"/> 28. Headache	Has any of your immediate family ever had any of the following (please state relationship)	
<input type="checkbox"/> 7. Tuberculosis	<input type="checkbox"/> 29. Depression	Tuberculosis	
<input type="checkbox"/> 8. Other lung infections	<input type="checkbox"/> 30. Anxiety	Diabetes	
<input type="checkbox"/> 9. Rheumatic fever	<input type="checkbox"/> 31. Emotional disorder	Cancer	
<input type="checkbox"/> 10. Heart murmur	<input type="checkbox"/> 32. Mental problems	Heart Disease	
<input type="checkbox"/> 11. Chest pain	<input type="checkbox"/> 33. Skin problems	High Blood Pressure	
<input type="checkbox"/> 12. Rapid heart beat	<input type="checkbox"/> 34. Measles(Red/Rubeola)	Kidney Disease	
<input type="checkbox"/> 13. Faint during/after exercise	<input type="checkbox"/> 35. Measles(German/Rubella)	Other	
<input type="checkbox"/> 14. Ulcer (Stomach/Duodenal)	<input type="checkbox"/> 36. Mumps		
<input type="checkbox"/> 15. High blood pressure	<input type="checkbox"/> 37. Chickenpox		
<input type="checkbox"/> 16. Recurrent diarrhea	<input type="checkbox"/> 38. Gynecological problem		
<input type="checkbox"/> 17. Colitis/enteritis	<input type="checkbox"/> 39. Herpes/ Genital infection		
<input type="checkbox"/> 18. Hepatitis: Type _____	<input type="checkbox"/> 40. Back problem		
<input type="checkbox"/> 19. Bladder or kidney infection	<input type="checkbox"/> 41. Bone or joint problem		
<input type="checkbox"/> 20. Kidney stone	<input type="checkbox"/> 42. Sports-related injury		
<input type="checkbox"/> 22. Blood clotting problems	<input type="checkbox"/> 43. Alcohol or drug use		
<input type="checkbox"/> 23. Congenital/Birth defects	<input type="checkbox"/> 44. Eating Disorder		
<input type="checkbox"/> 45. Learning disability specify _____			

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

