Phone: 864-656-3076 **Fax: 864-656-1123**

CLEMSON RURAL HEALTH

MEDICAL SURVEILLANCE PROGRAM ENROLLMENT

All questions contained in this document are strictly confidential and will become part of your medical record. Please fill in as much of the information as possible so that we may maintain accurate records.

PATIENT INFORMATION

Name *(Last, First, M.I.):*		
Preferred Name or Alias:		
Date of Birth:		
Sex: ☐ Male ☐ Female ☐ Other ☐ Prefer Not To Disclose		**Contact Information:**
Home address:		**Home Phone:**
City:		**Work Phone:**
State:	**Zip Code:**	**Mobile Phone:**
County:	**Country:**	**Email:**

GENERAL INFORMATION

Marital status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Significant other ☐ Widowed ☐ Unknown

Veteran Status: ☐ Non Veteran ☐ Active Duty ☐ Guard/Reserves ☐ Veteran

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown **Needs Interpreter?** ☐ Yes ☐ No

Written Language: **Preferred Language:**

Race ☐Caucasian (White) ☐American Indian or Alaska Native ☐African American (Black) ☐Native Hawaiian or Other Pacific Islander ☐Other

Education Level: ☐ Elementary ☐ High school ☐ Vocational ☐ College ☐ Graduate/professional

Employment Status: ☐ Full Time ☐ Student Full Time ☐ Self Employed ☐ Retired Date _____ ☐ Not Employed
☐ Part Time ☐ Student Part Time ☐ Active Military ☐ Disabled ☐ Unknown

Are you employed at Clemson University? ☐ Y ☐ N	**Are you a student at Clemson University?** ☐ Graduate ☐ Undergraduate
Department:	**Major:**
Occupation:	**Faculty Name:**
Supervisor's Name:	**Course:**

INSURANCE INFORMATION

Medical Surveillance is provided at no cost to the enrollee; you are not required to submit your insurance information, but can do so if you would like to engage in other services at Clemson Rural Health – Joseph F. Sullivan Center.

Name (Last, First, M.I.):	**Patient relation to Guarantor:**
Subscriber's Name on card:	**Patient relationship to Subscriber:**
Subscriber's Date of Birth:	**Sex**: ☐ Male ☐ Female ☐ Unknown

Home address: **City:** **State:** **Zip Code:**

Insurance Co Name:

Policy #:	**Group Number:**

PREFERRED MECHANISM TO RECEIVE INFORMATION FROM MEDICAL SURVEILLANCE PROGRAM

Please select below how you would like to receive information from the MSP Occupational Health Nurse:

☐ Pick up from 101 Edwards Hall ☐ Mail ☐ ~~Encrypted Email~~

Combined Medical Surveillance Program Acknowledgement and Consent Form:

I understand that as part of my Medical Surveillance Program (MSP) healthcare, Clemson Rural Health – Joseph F. Sullivan Center (CRH-JFSC) creates and maintains a medical record describing my health history, symptoms, examination, test results, diagnoses, treatment plan, etc. By signing below, I consent to treatment by the MSP at CRH-JFSC, including office visits, laboratory testing, office procedures, or other treatment directly related to MSP. I understand that CRH-JFSC is an academic nursing center that supports the mission (teaching, research and service) of Clemson University. I understand that students, supervised by faculty professionals, are an integral part of operations. I understand that services provided under MSP are offered at no cost to me.*

Signature: _____ **Date:** _____

Printed Name: _____

PLEASE RETURN COMPLETED PAPERWORK CRH-JFSC BY DROP OFF (101 EDWARDS HALL) OR SECURE FAX (864-656-1123)

Phone: 864-656-3076 **Fax: 864-656-1123**

CLEMSON RURAL HEALTH

MEDICAL SURVEILLACE PROGRAM HEALTH HISTORY

Please select all possibly hazardous exposures in your job/research:

Animals:	☐Aquatic	☐Birds	☐Farm	☐Insect	☐Lab	☐Wild
Animal Populations:						
Human/Primate:	☐Blood	☐Blood product				
Environmental:	☐Chemicals	☐Dust	☐Noise			
☐Other:						

☐Yes	☐No	I will be exposed to animal populations that may carry rabies.
☐Yes	☐No	I will be involved in recombinant DNA technology, Human Gene Transfer, or Xenotransplatation.
☐Yes	☐No	(For women only): I am pregnant or planning to become pregnant within the next year.

Medical History (mark all that apply): ☐ I have no significant medical history

☐ Anemia	☐ Arthritis	☐Cancer	☐Diabetes
☐Difficulty Smelling	☐Dizziness or Fainting	☐Hearing Problems	☐Heart Problems
☐Heat Stroke	☐High Blood Pressure	☐Joint or Muscle Problems	☐Kidney or Liver Disease
☐Rheumatic/Scarlet Fever	☐Seizures/Epilepsy	☐Stomach/Bowel Problems	☐Tuberculosis
☐Vision Problems	☐Other: _____		

☐Yes ☐No I have a medical condition or take medications/treatments that impair my immune system (such as HIV, cortisone, chemotherapy, radiation).

☐Yes ☐No I have a pre-existing cardiac valvular disease or have a vascular graft.

Please list all current medications: _____

_____

_____

Allergy History:

Do you have or have you had any of the following diseases or conditions?

			When	Explanation
☐Yes	☐No	Asthma/Wheezing		
☐Yes	☐No	Chronic Cough/Bronchitis		
☐Yes	☐No	Eczema/Skin Rash		
☐Yes	☐No	Hay Fever/Seasonal Allergies		
☐Yes	☐No	Itchy, irritated eyes		
☐Yes	☐No	Shortness of Breath		
☐Yes	☐No	Other lung/breathing problems		
☐Yes	☐No	Allergies to food or medicines (list):		
☐Yes	☐No	Allergies to pollen, grass, weeds, trees, yeast or mold (list):		
☐Yes	☐No	Allergies to latex, chemicals, or other substances (list):		
☐Yes	☐No	Allergies to animals (list):		

Immunization History

Year	Year	Year
Teatanus/Td:	Tdap:	Hepatitis B (date of series completion):
Rabies:	TB test:	

By signing this document, I certify that the health information provided is complete and accurate to the best of my knowledge.

Signature: _____ Date: _____

Print Name: _____ Date: _____

***Services Covered by Medical Surveillance:**

- Audiometry screening (as indicated)
- DOT Exam (as indicated)
- Immunizations (as indicated) – Hepatitis A and B, Rabies, Tetanus/Td or Tdap
- Medical examination by licensed healthcare provider
- Medical Surveillance Enrollment Review
- Respirator review (as indicated)
- Tuberculosis screening
- *Other services may be recommended but will be billed to the patient as indicated for CRH-JFSC services outside of the scope of MSP*

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