Dear Student:

CONGRATULATIONS on your acceptance to the University of Rhode Island! You are now a Rhody Ram!
The Dr. Pauline B. Wood Health Services, conveniently located in the Potter Building adjacent to the
resident halls complex, is a comprehensive ambulatory health center that is nationally recognized through
accreditation by The Joint Commission.

We welcome you and want to be of service for your healthcare needs during the academic year. In order
that we may better serve your health needs, we will maintain an individual health record for you. It is of
vital importance to the quality of your care that you provide us with as accurate a health history as
possible. To this end, you must register for and login to our Patient Portal to submit required health
forms. You can access this via health.uri.edu and selecting the Patient Portal menu where detailed
instructions can be found.

The information you input and upload in the Patient Portal will become a permanent part of your
electronic health record (EHR) and ensure continuity of care. Academic acceptance of a student at the
University is not contingent on medical clearance. Your acceptance cannot be influenced in any way by
your medical report to us, and all information you provide us with is strictly confidential.

Services provided by URI Health Services include: ambulatory medical services; office visits; specialty
clinics; allergy; wart and immunization services; psychiatric services; pharmacy; x-ray and laboratory
services on site. Our Health Education Department provides health education and promotion programs
along with nutritional services and counseling. More information, including our New Student Health
Forms is available at health.uri.edu.

All full-time and international students must have health insurance. A health insurance charge has been
added to your bill. If you have comparable health insurance coverage, you may waive the health insurance
charge. Please go to health.uri.edu and click on the Health Insurance Waiver menu for details.

We desire to be your most sought-after health care provider, and we are committed to providing a user-
friendly, compassionate, inclusive, caring and confidential environment.

We are excited to have you join the URI community. We have an EHR to better meet your health and
wellness needs. The system facilitates self-check-in, a patient portal, and other steps to getting you the
care you need.

On behalf of our staff, we want to extend our best wishes for a healthy, pleasurable and rewarding
educational experience at the University of Rhode Island.

If you have any questions or concerns or are interested in a tour of our facility, please contact Health
Services at (401)874-2246 or health@uri.edu.

Sincerely yours,

Ellen M. Reynolds, MS
Director
URI Health Services

Fortunato Procopio, MD
Medical Director
URI Health Services

The University of Rhode Island is an equal opportunity employer committed to the principles of affirmative action.
The URI Health Services Patient Portal allows a secure means for you to communicate with Health Services in an easy electronic format. You must register for the Patient Portal if you are a full time student (not required for part-time students, unless you have paid the Health Services fee.)

Students must register online and create a password to ensure confidentiality of health information.

1. Go to health.uri.edu and click on the Patient Portal tab.
2. Click on “Sign Up” if you have not previously registered or “Login” if you have already registered for the Patient Portal.
3. Enter a username — we suggest you use your Student ID # ("100" #).
4. Enter University ID (your “100” #).
5. Click Submit.
6. You will be prompted to create a password. Your password must be at least 8 characters, a combination of letters and numbers, and at least one upper case letter.

** If you receive a message stating the username is already in use, click on the "Forgot Password" link. Type in the email address that URI has on record for you (most likely your my.uri.edu email address unless you have changed it). An email will be sent to that email account. Please click the first link in the email and follow the instructions.

If you have any questions or difficulties registering, please contact the Health Information Management Department at (401) 874-2246

Monday – Friday, 8:00 am – 3:30 pm.

Connect with Health Services for up-to-date information!

@URIHealthSvcs
STUDENT AND EMERGENCY CONTACT FORM

This form can be completed directly online in the Patient Portal. If you complete the online form, you do NOT need to print, complete, and upload this form.

Student Contact Information:

College ID # _______________________________ Student Cell Phone # (REQUIRED) _______________________________

Name _______________________________ Date of Birth _______________________________

LAST FIRST M.I. MM/DD/YYYY

Home Address _______________________________

STREET CITY, STATE ZIP CODE

Home Phone Number _______________________________

PHONE # (INCLUDING AREA CODE)

Status: ☐ Full Time ☐ Part Time ☐ Undergraduate ☐ Graduate

Age __________ Place of Birth _______________________________ Race _______________________________

☐ Female ☐ Male

While Health Services recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronoun are different from these, please let us know.

Emergency Contact Information:

Specify person to be notified in case of emergency: _______________________________

NAME

STREET CITY, STATE ZIP CODE

PHONE # (INCLUDING AREA CODE) CELL PHONE # (INCLUDING AREA CODE)

Name of Primary Care Provider _______________________________

Provider’s Address _______________________________

STREET CITY, STATE ZIP CODE

Provider’s Phone Number _______________________________

PHONE # (INCLUDING AREA CODE)
PHYSICAL EXAMINATION

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING HEALTH.URI.EDU

To Student's Physician: We would appreciate completion and your signature.
If you have any questions regarding our services, please call (401) 874-2246.

* Use of this form is not required; your provider may copy their form if previous exam was within 18 months.

STUDENT NAME:      DATE OF BIRTH: ________________
(Please print) Last Name First Name MI

Weight: ___________ Height: ___________ BP: ___________ Pulse: ___________ Respiration: ___________

PHYSICAL EXAM:       □ NORMAL          □ ABNORMAL
IDENTIFY ABNORMALS:

IMPRESSION (diagnoses, recommendations, restrictions).
Please note any health problem, chronic health condition or disability that may affect behavior or health of the student while at college.

<table>
<thead>
<tr>
<th>ALLERGIES (Please list ALL allergies to medications, foods and other miscellaneous items)</th>
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<tr>
<td>MEDICATION ALLERGIES:</td>
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<td>FOOD ALLERGIES:</td>
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<td>OTHER ALLERGIES:</td>
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<tr>
<td>□ BEES       □ LATEX       □ NUTS       □ SEASONAL / POLLEN</td>
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<tr>
<th>MEDICATIONS (Include prescriptions, over-the-counter, and herbal)</th>
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<td>NAME</td>
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PROVIDER SIGNATURE: ___________________________ DATE OF EXAMINATION: ________________

PROVIDER NAME: ___________________________ PHONE: ___________________________ FAX: ___________________________

ADDRESS: ___________________________
Immunization Record

Student Name: ____________________________________________ Date of Birth: ________________

(Please print) Last Name First Name MI

While Health Services recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that your legal name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronoun are different, please let us know.

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required at least one month apart or positive immune titer verifying immunity.

  MMR Dose 1 / / OR Positive Titer / /
  Dose 2 / / OR Positive Titer / /

- **HEPATITIS B:** Three doses (doses one and two given four weeks apart and the third dose should be at least four months after first dose) or positive immune titer verifying immunity.

  Dose 1 / / OR Positive Titer / /
  Dose 2 / / OR Positive Titer / /
  Dose 3 / / OR Positive Titer / /

- **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap):** Tdap / / *

  * Tdap – One dose of Tdap is required in lifetime (not to be confused with childhood DTaP vaccine)

- **TETANUS (Td or Tdap):** Tdap / / / * OR Td / / *

  * Td or Tdap booster is required within the past 10 years. If first and only Tdap was given in the past 10 years, requirement is met.

- **MENINGOCOCCAL VACCINE:** (MCV4) Dose 1 / / OR Disease History / / *

  * Required if under 22 years old. If you were vaccinated prior to your 16th birthday, a booster dose is also required.

- **VARICELLA:** Two doses of chicken pox vaccine are required at least one month apart or positive immune titer verifying immunity or medical provider’s documented history of disease.

  Dose 1 / / OR Positive titer / /
  Dose 2 / / OR Disease History / /

- **TUBERCULOSIS:** * COMPLETE Tuberculosis (TB) Screening Form (page 4) and, if required, TB Risk Assessment (page 5).

- **SEASONAL FLU:** / / 

- **HEPATITIS A:** Dose 1 / / Dose 2 / /

- **HUMAN PAPILLOMAVIRUS VACCINE (HPV):** Dose 1 / / Dose 2 / / Dose 3 / / 

- **MENINGOCOCCAL SEROGRUP B:** Dose 1 / / Dose 2 / / Dose 3 / / *

  * This is not the same as Meningococcal (MCV4)

- **POLIO:** / / 

- **OTHER IMMUNIZATIONS:**

- **MEDICAL / RELIGIOUS EXEMPTION:** Yes * Exemption Certificate Required

Health Care Provider: ___________________________ Date: ___________________________

(Please print)

Signature and Title: ___________________________ Office Phone: ___________________________
Please answer all of the following questions:

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

2. 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

3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? (If yes, please CIRCLE the country/ies below) Yes No

4. Have you had frequent or prolonged visits to one or more of the countries listed below with a high prevalence of TB disease? (If yes, CHECK the country/ies below) Yes No

5. Have you ever been a volunteer or healthcare 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 NO to all of the above questions, no further testing or action is required.

If the answer is YES to any of the above questions, The UNIVERSITY OF RHODE ISLAND requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. Please have your health care provider complete the enclosed yellow TB Risk Assessment form (page 5) prior to your arrival on campus.

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2013. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata
TUBERCULOSIS (TB) RISK ASSESSMENT

Student Name: _______________________________ College ID #: ________________________________________

To be completed by health care provider ONLY if required based on TB Screening Form

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

1. Does the student have signs or symptoms of active pulmonary tuberculosis disease?
   Yes   No
   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
   Unexpected 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: _/__/__ Date Read: _/__/__
   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 ≥ 15 mg/d of prednisone for ≥ 1 month)
   • Persons with HIV/Aids
   > 10 mm is positive continued:
   • 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, 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.

3. Interferon Gamma Release Assay (IGRA)
   Date Obtained: _/__/__ (specify method) QFT-G QFT-GIT T-Spot Other
   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

HEALTH CARE PROVIDER:
Name: _______________________________ Signature: _______________________________
Address: _______________________________ Phone: (__ ____) _______ _______
Authorization for Medical Care and Treatment of a Minor

NOTE: This consent form only needs to be completed and uploaded if the student is a minor (under 18 years of age). For all minors, a signed authorization by parent/guardian is required prior to treatment at URI Health Services.

Student Name: _______________________________
Date of Birth: _______________________________
Student ID #: _______________________________
Student Cell Phone #: __________________________

PARENTS / GUARDIANS OF STUDENTS UNDER 18 YEARS OF AGE
PLEASE COMPLETE THIS SECTION

I hereby grant permission to University of Rhode Island Health Services to provide any medical treatment for my son/daughter ___________________________ deemed necessary by the Health Services staff.

_____________________________  _______________________________
PARENT/GUARDIAN SIGNATURE                                                                                     DATE

_____________________________  _______________________________
PRINT NAME                                             PARENT/GUARDIAN CELL PHONE NUMBER

_____________________________
RELATIONSHIP TO STUDENT
IMPORTANT NOTE
REGARDING INTERCOLLEGIATE NCAA ATHLETICS

If you are planning on participating in intercollegiate athletics, the following information is very important. Please read it carefully so that you will be able to provide the required information and documentation for athletic participation.

- Go to gorhody.com

- Select “Inside Athletics” from the menu bar; then “Sports Medicine” from the drop down menu.

- Select Student-Athlete Forms

- Select either:
  - Online Medical Form Instructions (All Student-Athletes)
  - Walk-on/Student-Athlete Tryout Waiver

- The Athletic Department will require a copy of the physical examination, results of sickle cell screening, and a copy of your insurance card indicating insurance coverage.

*We strongly recommend that this necessary physical exam for tryouts/walk-on students be carried out prior to your arrival on campus. It is the responsibility of the student to ensure that this information is available prior to tryouts.*