KENTUCKY STATE UNIVERSITY

ACCEPTANCE PACKET

IN ALL THINGS **EXCELLENCE**

IMPORTANT NUMBERS:

Financial Aid
502-597-5960

Admissions
502-597-6813

Residence Life
502-597-5951

Bursars Office
502-597-6278

Athletics
502-597-6011

Campus Police
502-597-6877

Student Health Services
502-597-6271

Intent to Enroll Response Form

Complete Intent to Enroll Response Form online
or mail to
Office of Admissions
Kentucky State University
400 E. Main St.
Frankfort, KY 40601

___ I intend to enroll at Kentucky State University in ☐ Spring ☐ Fall Semester _____ Year

___ I do not intend to enroll at Kentucky State University in ☐ Spring ☐ Fall Semester _____ Year

Campus Wide ID # (see acceptance letter): _____

_____
Print Name (Last, First, Middle)

_____
Home Address (number and street)

_____
City State Zip Code

_____
Mailing Address, if different from above (number and street)

_____
City State Zip Code

Home telephone (with area code): _____

Cell phone (with area code): _____

Email address: _____

Alternate email address: _____

_____
Signature Date

12/21/2016

Consent to Release Educational Records

I, _____, understand that the Family Educational Rights and Privacy Act (FERPA) grants me certain rights concerning my education records. Notwithstanding these rights, I consent to the release of my educational records to my parent(s) or guardian(s) listed below for the purpose of keeping them informed about my education at Kentucky State University. I understand that education records include, but are not limited to, information about my academic standing, disciplinary issues, and financial obligations to the University.

This consent will remain in effect until I graduate or withdraw from the University. I understand that I may submit a subsequent notification in writing directing the University to no longer release information to any or all of the individuals listed below.

Kentucky State University is authorized to release educational information to the following individuals:

Name	Relationship to Student
Name	Relationship to Student
Name	Relationship to Student

Date

Student Name

Student Signature

Student Date of Birth

Student ID

Rev. 2/17/16

Dear Thorobred:

Student Health Services recommends all students submit the **Medical History Form**, **Preventative Health Care Examination Form,** and an **Immunization Record** prior to attending Kentucky State University.

Documentation from a doctor or clinic regarding the following immunizations is recommended:

- Preventative health care examination completed by doctor or clinic within the past six months
- Tuberculin Skin Test within the past six months
- Copy of chest X-ray if history of positive tuberculin test

Recommended immunizations include:

- Polio Series (x 4)
- Adult Tdap (within the past 10 years)
- Meningitis Vaccine (up to age 26)
- Mumps (MMR x 2 or documentation of disease)
- Varicella Vaccine/Chicken pox (x 2 or documentation of disease)

Note: Documentation of disease should be verified or signed on a physician's or clinic's letterhead.

Please send the following completed forms and immunization record to:

Office of Admissions
Kentucky State University
ASB Suite 312
400 E. Main St.
Frankfort, KY 40601

Or fax to: (502) 597-5814

Thanks for your cooperation!

Sincerely,

Floarine A. Wilson, APRN
Director, Betty White Health Center

Medical History Form

INSTRUCTIONS AND INFORMATION:

1. We recommend this form be returned to the address below within 30 days or no later than 14 days prior to enrollment. All pages must be completed.
2. We recommend this form be completed by all new students and students who have been away from the University for more than 10 months. We also recommend students entering graduate school complete this form.
3. Information on this form is CONFIDENTIAL, is for Kentucky State University Student Health Services, will not be released without the student's consent, and will not affect admissions status.
4. **Send completed forms to:** Office of Admissions
   Kentucky State University
   ASB Suite 312
   400 E. Main St.
   Frankfort, KY 40601
   Fax: (502) 597-5814

IDENTIFICATION

ID Number (see acceptance letter): _____

_____
Name (last, first, middle)

_____
Home Address (number and street)

_____
City State Zip Code Country

Home Telephone: (_____)_____

Cell Phone: (_____) _____

Email: _____

Date of Birth (Month-Day-Year): _____

Sex (optional): ☐ Male ☐ Female

Emergency Contact: _____

Emergency Contact Phone Number: (_____) _____

Medical History Form

Seizures: ___ Yes ___ No Comments: _____

Chronic Diseases: _____

Allergies: _____

Drug Allergies: _____

Medications: _____

Significant Historical Information: _____

IMMUNIZATIONS:

We recommend a certificate from a doctor's office/clinic as proof of immunization.

1. **Tdap (tetanus/diphtheria/pertussis):** Recommended within the last ten years.
2. **Polio Series:** Recommended if student is 18 years or younger.
3. **Mumps:** Recommended immunization if no history of illness.
4. **Measles (rubelola):** Recommended documentation of two MMR vaccines. Either a certificate of immunization dated 1969 or later or proof of positive titer suggested. Copy of lab report may be submitted. History of illness is not sufficient.
5. **Tuberculin Skin Test:** Recommended within six months prior to start of class. The documentation should state the test results were negative or positive. CHEST XRAY IS STRONGLY RECOMMENDED EVERY YEAR IF TUBERCULIN SKIN TEST WAS REPORTED POSITIVE.
6. **Menactra / Meningitis:** Vaccine is recommended for all incoming new students up to age 26. Vaccine is also recommended for older or transferring students living on campus.
7. **Varicella (chickenpox):** Recommended to have two vaccines or history of the chickenpox disease prior to starting KSU.

HEALTH HISTORY AND PHYSICAL ASSESSMENT

Students who submit the health history form or copy of past immunizations will be notified of the immunizations that need to be updated prior to the start of class. Students should submit the health history form completed by a doctor's office or clinic within the past six months.

Preventative Health Care Examination Form

IDENTIFYING INFORMATION

Student Name (last, first, middle) _____

ID Number: _____ Date of Birth:_____

MEDICAL HISTORY

Seizures: _____

Chronic Illness: _____

Allergies: _____

Drug Allergies: _____

Medications: _____

Significant Historical Information: _____

_____

PHYSICAL EXAM:

N	Abn		
_____	_____	General Appearance	Hgt:_____ Wgt:_____ BP:_____/_____
_____	_____	HEENT	Hearing: R_____ L_____
_____	_____	Skin	Vision: R_____/_____ L_____/_____
_____	_____	Neck	Optional:
_____	_____	Chest	HCT/HGB:_____ UA:_____
_____	_____	Heart	
_____	_____	Abd-Genitalia	
_____	_____	Extremeties-Back (including scoliosis for 6th grade)	
_____	_____	Neuro	

Explain Abnormal Exam: _____

_____

RECOMMENDATIONS:

_____ No restrictions - normal exam

_____ Restrictions and suggestions to school: _____

_____

_____

Signed:_____ Date: _____

Physician/ARNP/PA/EPSDT Provider

Address:_____ Telephone: _____

Mail completed form to: Office of Admissions, Kentucky State University, ASB Suite 312, 400 E. Main St., Frankfort, KY 40601 or fax to (502) 597-5814

Rev 2/22/16