PHILADELPHIA
UNIVERSITY

Student Health Medical Record

Student Health Center
4201 Henry Avenue
Philadelphia, PA 19144-5497

Must Read Instructions:

1. Save the attached envelope to mail your completed health form. ALL FOUR PAGES MUST BE COMPLETED.
2. Provider must sign physical and immunization record.
3. Original Student Health Medical Record must be mailed. Faxes and copies will not be accepted.
4. Titers are the only attachments accepted.

PERSONAL IDENTIFICATION

Entering Philadelphia University: _____ _____
Month Year

Program of Study: _____

Undergrad _____ Graduate Student _____

Student ID Number: _____

Name _____
(last, first, middle)

_____
(Home address number and street)

_____
City State Zip Code Country

Cell Phone (Student): _____

Email Address (Student): _____

Father's Name: _____
(last, first)

Mother's Name: _____
(last, first)

Sex: ❑ Male ❑ Female

Race: ❑ Caucasian ❑ Black ❑ Asian ❑ Other

Citizenship: ❑ U.S. ❑ Other _____
(Specify)

Home Telephone Number: _____

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

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

_____
Name (last, first) Relationship

_____
Address

_____
City State Zip Code

_____
Country (e.g., USA, India)

_____
Home Telephone Number

_____
Cell Telephone Number

_____
Business Telephone Number

HEALTH INSURANCE INFORMATION

Completing the health insurance information is optional. The online insurance waiver must still be completed unless you desire to purchase the University-sponsored plan.

This information may be faxed to a local drug store as needed. This facilitates the delivery of your prescription medication to the Student Health Center.

Please read each of the following statements and check the one that best describes your current health-medical insurance coverage. Additionally, respond to any information requested under the category.

❑ Student has coverage through family insurance.

_____
Insurance Company Policy Number

_____
Insurance Company Address Group Number

_____
Policy Holder

_____
Insurance Company Phone Number

If the coverage is with a HMO or requires the use of a PPO, please be sure coverage is available in the Philadelphia area.

❑ Student also has prescription coverage.

_____
Insurance Company Policy Number

_____
Insurance Company Address Group Number

_____
Policy Holder

_____
Insurance Company Phone Number

❑ Student has coverage through a third party (e.g., Public Assistance, Medicare, etc.).

_____
Agency Name

_____
Agency Address

Please be sure coverage is available in the Philadelphia area.

❑ Student has no coverage and will be only utilizing the recommended University student-health insurance.

If the following changes occur, please notify Health Services:

- Insurance coverage
- Emergency contact information

Past Medical History

Have you had any of the following? Select "yes" or "no" to all questions about your personal medical history and briefly comment on "yes" answers in the space provided (dates, complications, etc.)

Comments:	Yes	No	Comments:	Yes	No
Abnormal Bleeding Tendency			Heart Condition		
Addiction			Hepatitis		
Asthma			High Blood Pressure		
Cancer			Infectious Mononucleosis		
Colitis or Colon Problems			Kidney Disease		
Depression/Anxiety			Rheumatic Fever		
Diabetes			Severe Headaches		
Diminished Hearing			Severe Visual Problems		
Eating Disorder			Thyroid Disease		
Epilepsy, Convulsions or Seizures			Tuberculosis		
Gall Bladder or Liver Disease			Other		
Gastric or Duodenal Ulcer					

Hospitalizations
(please list date and diagnosis)

Surgical Procedures
(please list date and procedure)

List All Current Medications
(prescribed and over-the-counter)

Drug Allergies

❑ None

PHYSICAL EXAMINATION

<u>TO THE EXAMINING HEALTH-CARE PROVIDER</u>: Please review the student's history and complete the physical examination and the immunization information. Please comment on all positive answers.

PART I – TO BE COMPLETED AND SIGNED BY HEALTH-CARE PROVIDER.

All information must be in English.

_____

Last name First name Middle name

Blood Pressure _____ Pulse_____ Height _____ Weight _____ lbs. BMI _____

Vision: Right 20/ _____ Corrected to 20/_____ with ☐ glasses ☐ contacts
Left 20/ _____ Corrected to 20/_____ with ☐ glasses ☐ contacts

CLINICAL EVALUATION

Check each item in proper column.	Normal	Abnormal	Comments
1. Head, Neck, Face, and Scalp			
2. Nose and Sinuses			
3. Mouth and Throat			
4. Teeth and Gingiva			
5. Eyes (lids, conjunctiva)			
6. Pupils and Ocular Motion			
7. Lungs, Chest and Breast			
8. Heart (include estimate of cardiac function)			
9. Vascular System (include varicosities)			
10. Abdomen and Viscera (include hernia)			
11. Ano-rectal and Pilonidal (optional)			
12. Endocrine System			
13. G-U System (optional)			
14. Upper Extremities			
15. Lower Extremities and Feet			
16. Spine; other Musculoskeletal			
17. Skin and Lymphatics			
18. Neurologic			

To the Health-Care Provider: After completing the medical history and physical examination, please answer these questions regarding participation in intercollegiate athletic competition.

❑ Cleared for all sports without restrictions ❑ Cleared for all sports with restriction ❑ Not cleared for any sports

Explain _____

_____

Signature of Health-Care Provider *Date* *Telephone Number ( )*

_____

Address

IMMUNIZATION RECORD

Last Name: _____ First Name:_____ Middle Name: _____

PART II- TO BE COMPLETED AND SIGNED BY HEALTH-CARE PROVIDER.
Do not send attachments unless needed to verify immunity.

Varicella 2 doses required without evidence of immunity.	___/___ Mo Yr	___/___ Mo Yr	___/___ Mo Yr **Quantitative Varicella Antibody** validates immunity. (include a copy with this form.)	___/___ Mo Yr physician documented disease
Tetnus-Diptheria-Pertussis (last dose Tdap)	___/___ Mo Yr	**Must be given after May 2005. Adacel or Boostrix are acceptable.**		
Polio (last dose of series)	___/___ Mo Yr			
Measels Mumps Rubella 2 doses required without evidence of immunity. OR Positive Antibody	___/___ Mo Yr	___/___ Mo Yr	**MMR Titers** validates immunity. (include a copy with this form.)	
Meningococcal Tetravalent	___/___ Mo Yr	**Revaccinate if ≥ 5 years since last vaccine. Required for all resident students (SB955)**		
Hepatitis B Appropriate vaccinations OR Positive Antibody	___/___ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ___	___/___ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ___	___/___ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ___	___/___ Mo Yr **Hepatitis B Surface Antibody** validates immunity. (include a copy with this form.)
Hepatitis A (recommended)	___/___ Mo Yr	___/___ Mo Yr		
Quadravalent Human Papillomavirus Vaccine (recommended)	___/___ Mo Yr	___/___ Mo Yr	___/___ Mo Yr	

Tuberculin Skin Test (PPD) (Required within 6 months prior to matriculation) The need for this testing will be determined by your physician, and will be made according to your risk factors.

Date Given: ___/___/___ (M D Y) Date Read: ___/___/___ (M D Y) (must be read 48-72 hours after receipt)

Result: _____mm of induration **Interpretation: positive_____ negative_____

Interferon Gamma Release Assay (IGRA) - optional for students who have received BCG.

Date Obtained ___/___/___ (M D Y) (specify method) ☐ QFT-G ☐ QFT-GIT ☐ T 5pot

Result: negative _____ positive____ intermediate____

Chest x-ray (required if TST or IGRA is positive)

Date of chest x-ray: ___/___/___ (M D Y) Result: normal _____ abnormal____

Signature of Health-Care Provider *Date* *Telephone Number ( )*

Address