



Student's Last Name: _____ First: _____

Date of Birth: ____/____/____

Please complete this form and return it to Student Health Services. This form must be completed and the immunization requirements met before you will be allowed to attend classes. All information contained in this form will be held in confidence and will not be released to anyone on or off campus without your knowledge and consent.

PERSONAL IDENTIFICATION

Name Last Name First Name Middle Name Preferred Name

Address Street City State Zip

Sex assigned at birth Current gender identity: M/F/T Other

Date of Entry M/Y Date of Birth M/D/Y School ID#

Status: Part-time Full-time Graduate Undergraduate

Program of Study:

Student Cell Phone: Student Email:

Parent/Guardian Name: Parent/Guardian Name:

Citizenship: U.S. Other

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name Last Name First Name Relationship

Address Street City State Zip

Phone HOME Telephone Number CELL Telephone Number BUSINESS Telephone Number

HEALTH INSURANCE INFORMATION: Please attach a copy of the front and back of your current Health Insurance Card.

The online insurance waiver must be completed unless you desire to purchase the University-sponsored insurance plan.

For more information, check the school's STUDENT ACCOUNTS webpage.

CONSENT FOR TREATMENT/INFORMATION RELEASE

The undersigned herewith:

- A. Grants permission to Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services to provide medical care including administration of treatments and medications as necessary. This includes emergency room visits, lab work, x-rays, etc., which may need to be done at local facilities including local emergency departments, hospitals and medical practices, local imaging and lab locations.
B. Authorizes Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services, Disabilities Services and/or Athletic Trainers/Sports Medicine Services to exchange and release information to each other that may affect my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/screening and Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services health evaluation, immunization record, consent for treatment and questionnaire.
C. This form will remain valid until you graduate from Jefferson (Philadelphia University + Thomas Jefferson University) or cease to be enrolled at the University, whichever is earlier.
D. Certifies that the answers to the questions on this Health Record are correct and true.

*Parent/Guardian must co-sign if student is under age 18.

Student Signature

Date

Parent/Guardian Co Sign Signature if student is a minor

Date

DUE DATES:

Fall Semester July 15

Spring Semester January 1

ATTACHMENTS OF IMMUNIZATION RECORDS WILL NOT BE ACCEPTED

Please remind your provider to complete and sign pages 2 & 3

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PAST HISTORY SECTION TO BE COMPLETED BY STUDENT/GUARDIAN: Please indicate problems you have now or may have had in the past. Please comment about any positive answers on a separate sheet of paper. This information is used solely as an aid to provide necessary health care while you are a student. It is considered confidential information and cannot be released to anyone without your permission.

Abdominal pain/Food intolerance	yes	no
AIDS, ARC, or positive HIV	yes	no
Alcohol Problem	yes	no
Allergies (seasonal)	yes	no
Anemia/Easy Bruising or Bleeding	yes	no
Anorexia	yes	no
Anxiety (frequent)/Nervousness	yes	no
Asthma/Wheezing	yes	no
Back Problems	yes	no
Bee Sting Reaction, Epi pen	yes	no
Bladder Infection (Cystitis)	yes	no
Bleeding Trait (Sickle Cell)	yes	no
Bronchitis	yes	no
Cancer (location _____)	yes	no
Chicken Pox	yes	no
Contacts/Glasses/Visual Problems	yes	no
Dental Problems	yes	no
Depression	yes	no
Diabetes	yes	no
Dizziness/Vertigo	yes	no
Drug dependency	yes	no
Dyslexia	yes	no
Ear Problems	yes	no
Eating Disorder	yes	no
Eczema	yes	no
Emotional or mental health issues	yes	no
Epilepsy	yes	no
Eye Problems	yes	no
Fainting/Dizziness	yes	no
Fibrocystic Breast Disease	yes	no
Gall Bladder Disease	yes	no
Heat Stroke or Exhaustion	yes	no
Headaches (frequent)	yes	no
Stress / Migraine	yes	no
Hearing Loss	yes	no
Heart Problems:		
Palpitations	yes	no
Rheumatic Heart	yes	no
Heart Murmur	yes	no
Chest pain with exercise	yes	no
(if any of above heart issues, must attach cardiologist report)		
Hepatitis	yes	no
Hernia	yes	no
High Blood Pressure	yes	no
Hypoglycemia	yes	no
Irritable Bowel Disorder	yes	no
Kidney problems	yes	no
Lyme Disease	yes	no
Marfan Syndrome	yes	no
Menstrual problems	yes	no
Mononucleosis - (give date_____)	yes	no
Nosebleeds	yes	no
Obesity (>20 lbs. overweight)	yes	no
Organ (loss of paired organ)	yes	no
Ovarian cyst	yes	no
Peptic Ulcer (gastric or duodenal)	yes	no
Phlebitis	yes	no
Pinched Nerve	yes	no
Pneumonia	yes	no
Rheumatic Fever	yes	no
Rheumatoid Arthritis	yes	no

Seizures or Convulsions	yes	no
Last seizure and type_____		
Sinus Problems	yes	no
Sickle Cell trait or disease	yes	no
Stomach Problems	yes	no
Suicide Attempt	yes	no
Date:_____		
Thyroid Problem	yes	no
Do you smoke?	yes	no
How long have you smoked?_____		
How often_____		
Do you use smokeless tobacco?	yes	no
How long?_____		
Do you drink alcohol?	yes	no
Approximate number of drinks per occasion:_____		
Number of drinking occasions per week:_____		
Drug use (past or present)	yes	no
Drug of choice:_____		
Have you ever been hospitalized?	yes	no
Please list reason and dates		

Other problems not listed: _____

Have you ever had: any broken bones?	yes	no
specify: _____		
Dislocations?	yes	no
specify: _____		
Pain or swelling of muscle or joint?	yes	no
Injury to tendons, ligaments or cartilage	yes	no
AC separation or shoulder injury	yes	no
Blow to the head that knocked you out?	yes	no
Concussion? _____ How many? _____		
Injury to the neck or back?	yes	no
Spinal Fusion?	yes	no

***If you require any kind of special accommodations please contact this office asap.**

Family History:

Have any of your relatives had:		
Cancer	yes	no
Diabetes	yes	no
Epilepsy	yes	no
Have Sickle Cell Trait	yes	no
Heart Disease	yes	no
High Blood Pressure	yes	no
Kidney Disease	yes	no
Tuberculosis	yes	no

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TUBERCULOSIS (TB) SCREENING/TESTING TO BE COMPLETED BY STUDENT/GUARDIAN

Please answer the following questions:

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

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? Yes No

(If yes, please CIRCLE the country, below)

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Solomon Islands
Algeria	Côte d'Ivoire	Iraq	Nauru	Somalia South Africa
Angola	Democratic People's	Kazakhstan	Nepal	South Sudan
Anguilla	Republic of Korea	Kenya	Nicaragua	Sri Lanka
Argentina	Democratic Republic of	Kiribati	Niger	Sudan
Armenia	the Congo	Kuwait	Nigeria	Suriname
Azerbaijan	Djibouti	Kyrgyzstan	Northern Mariana Islands	Swaziland
Bangladesh	Dominican Republic	Lao People's Democratic	Pakistan	Tajikistan
Belarus	Ecuador	Republic	Palau	Thailand
Belize	El Salvador	Latvia	Panama	Timor-Leste
Benin	Equatorial Guinea	Lesotho	Papua New Guinea	Togo
Bhutan	Eritrea	Liberia	Paraguay	Trinidad and Tobago
Bolivia (Plurinational	Estonia	Libya	Peru	Tunisia
State of)	Ethiopia	Lithuania	Philippines	Turkmenistan
Bosnia and Herzegovina	Fiji	Madagascar	Poland	Tuvalu
Botswana	French Polynesia	Malawi	Portugal	Uganda
Brazil	Gabon	Malaysia	Qatar	Ukraine
Brunei Darussalam	Gambia	Maldives	Republic of Korea	United Republic of
Bulgaria	Georgia	Mali	Republic of Moldova	Tanzania
Burkina Faso	Ghana	Marshall Islands	Romania	Uruguay
Burundi	Greenland	Mauritania	Russian Federation	Uzbekistan
Cabo Verde	Guam	Mauritius	Rwanda	Vanuatu
Cambodia	Guatemala	Mexico	Saint Vincent and the	Venezuela (Bolivarian
Cameroon	Guinea	Micronesia (Federated	Grenadines	Republic of)
Central African Republic	Guinea-Bissau	States of)	Sao Tome and Principe	Viet Nam
Chad	Guyana	Mongolia	Senegal	Yemen
China	Haiti	Montenegro	Serbia	Zambia
China, Hong Kong SAR	Honduras	Morocco	Seychelles	Zimbabwe
China, Macao SAR	India	Mozambique	Sierra Leone	
Colombia	Indonesia	Myanmar	Singapore	
Comoros				

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) Yes No

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

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? Yes No

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 YES to any of the above questions, Philadelphia University requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

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



Jefferson (Philadelphia University + Thomas Jefferson University) Student Health Services

Student's Last Name: _____ First: _____

Date of Birth: ____ / ____ / ____

Please attach a copy of the front and back of your insurance card here.

Extra space for additional Medical and/or Family history you feel would be important for us to know.

Student's Last Name: _____ First: _____

Date of Birth: ____/____/____

PHYSICAL ASSESSMENT *To be completed by a health care provider.

Drug & other allergies: (Circle) None or List Allergies _____

Latex allergy: Yes _____ No _____ (If yes please list type) _____

Pulse _____ Respirations _____ BP _____ Height _____ Weight _____ BMI _____

EXAM	Normal	Abnormal or additional elements
General	<input type="checkbox"/> NAD <input type="checkbox"/> WNWD	
HEENT	<input type="checkbox"/> Clear <input type="checkbox"/> pupils <input type="checkbox"/> Ears no d/c <input type="checkbox"/> TMs no bulging pearly, <input type="checkbox"/> nl light reflex <input type="checkbox"/> Mouth MMM <input type="checkbox"/> Throat no exudates or lesions	
Neck	<input type="checkbox"/> Supple <input type="checkbox"/> no bruit <input type="checkbox"/> no lymphadenopathy	
Chest	<input type="checkbox"/> CTA <input type="checkbox"/> symmetric	
Cardiovasc	<input type="checkbox"/> RRR <input type="checkbox"/> no murmur <input type="checkbox"/> nl PMI	
Breast	<input type="checkbox"/> no masses <input type="checkbox"/> deferred <input type="checkbox"/> no discharge <input type="checkbox"/> no lymphadenopathy	
Abdomen	<input type="checkbox"/> Soft, NTND <input type="checkbox"/> no masses <input type="checkbox"/> NABS <input type="checkbox"/> no CVA tend	
GU/GYN	<input type="checkbox"/> no d/c <input type="checkbox"/> no lesions <input type="checkbox"/> nontender <input type="checkbox"/> pap (if over 21) <input type="checkbox"/> deferred	
Back	<input type="checkbox"/> nontender <input type="checkbox"/> scoliosis <input type="checkbox"/> no deformity <input type="checkbox"/> neg. straight leg lift	
Musc-skel/ext.	<input type="checkbox"/> FROM <input type="checkbox"/> no edema <input type="checkbox"/> N/V intact	
Skin	<input type="checkbox"/> No rash <input type="checkbox"/> no suspicious nevi	
Neuro	<input type="checkbox"/> AAOX3 <input type="checkbox"/> nl reflexes <input type="checkbox"/> CN 2-12 intact <input type="checkbox"/> Sensory nl <input type="checkbox"/> motor func. nl	

Does the Student have signs or symptoms of active tuberculosis disease? NO YES

If YES proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, IGRA testing, chest x-ray, and sputum evaluation as indicated. All results and treatment plans must be included with this record before the student will be permitted on campus.

Prior surgeries: NO YES Please list: _____

Is this student under treatment for any medical or emotional condition? If yes, explain. _____

Limitations, special conditions or dietary needs: _____

Current Medications: (include dosage) _____

Team sports, Club sport, Fitness center, Fitness classes: _____

_____ Full Participation

_____ Limited Participation (describe limitations, restrictions, time frame and if follow -up evaluation needed.)

_____ Participation Contraindicated (list reasons). _____

PROVIDER STATEMENT: This student has been evaluated and found to be in good health and able to participate unless stipulated above.

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ()
Address	

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STUDENT IMMUNIZATION AND TUBERCULOSIS SCREENING DOCUMENTATION

MUST be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in English)

MMR (Measles, Mumps, Rubella) 2 doses required at least 28 days apart for students born after 1956 and all health care professional students. (PT, OT, RN, Midwifery)

MMR Vaccination	Date Dose 1: / / Date Dose 2: / /	AND titers for ALL health care professionals students Titrers Results:
Measles (Rubeola)	Measles/Rubeola (IgG), antibodies, titer Date: / /	
Mumps	Mumps (IgG), antibodies, titer Date: / /	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> EQUIV <input type="checkbox"/> Lab Report Attached Results:
Rubella	Rubella (IgG), antibodies, titer Date: / /	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> EQUIV <input type="checkbox"/> Lab Report Attached Results:

Varicella (Chicken Pox) 2 doses required at least 28 days apart. Health care professional students (PT, OT, RN, Midwifery) must also provide titers.

Dose #1 Date: / /	Varicella (IgG), antibodies, titer Results <input type="checkbox"/>	Date: / /
Dose #2 Date: / /	<input type="checkbox"/> POS <input type="checkbox"/> NEG <input type="checkbox"/> EQUIV	<input type="checkbox"/> Lab Report Attached

Tetanus/Diphtheria/Pertussis (TDAP) – Required within last 10 years – Recommended within 5 years of your start date.

Vaccine Date: / /

Hepatitis B Immunity - 3 doses required: Copy of titer results required ONLY for health care professional students (PA, OT, RN, Midwifery)

Primary Hepatitis B Series	Dose #1 Date: / /	Secondary Hepatitis B Series (if no response to primary series)	Dose #4 Date: / /
	Dose #2 Date: / /		Dose #5 Date: / /
	Dose #3 Date: / /		Dose #6 Date: / /
QUANTITATIVE Hep B Surface Antibody Results: mIU/ml <input type="checkbox"/> Lab Report Attached	Date: / /	QUANTITATIVE Hep B Surface Antibody Results: mIU/ml <input type="checkbox"/> Lab Report Attached	Date: / /

Tuberculosis Screening REVIEWED – Student answered NO to all screening questions and is low risk YES NO

PPD	Date: / / Date: / /	Results: _____ in mm Results: _____ in mm	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Negative
IGRA Blood Test	Date: / /	Results:	<input type="checkbox"/> Lab Report Attached

Positive History Only: Chest x-ray within 6 months required for all positive results

Chest X-ray	Date: / /	Results:	<input type="checkbox"/> Chest X-ray Report Attached
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Meningitis Vaccination – Required for students planning to reside in Jefferson (Philadelphia University + Thomas Jefferson University) housing

Living on campus housing <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of vaccine (if answered yes) Dose #1 / / Dose #2 / /	Date of declination / /	
Hepatitis A (RECOMMENDED)	Dose #1: / / Dose #2: / /	Combined Hepatitis A & B (RECOMMENDED)	Dose #1: / / Dose #2: / / Dose #3: / /
HUMAN PAPILLOMAVIRUS VACCINE (HPV4 or HPV9) (RECOMMENDED)	Dose #1: / / Dose #2: / / Dose #3: / /	MENINGITIS B VACCINE (AGES 16-18) (RECOMMENDED)	Dose #1: / / Dose #2: / / Dose #3: / /

MD/CRNP/PA-C Signature	Date
Printed Name	Phone # ()
Address	

MUST BE COMPLETED AND SIGNED. ATTACHMENTS OF IMMUNIZATION RECORDS WILL NOT BE ACCEPTED