Mount Aloysius College Student Health Record

Health Records are kept confidential

Health Services Office- St. Joseph Hall 100A-102
7373 Admiral Peary Highway, Cresson, PA 16630
(814) 886-6515 or (814)886-6391 Fax (814) 886-2978

Make copies for your records

Important!
Completion of this form is a pre-entrance requirement for all students. Forms must be completed and turned into Health Services prior to the start of classes.

To be completed by the student.
Parent/guardian must sign if student is under 18 years of age.

Major__________________ Year: Date of Admission __________ (M/Y
Please Notify Health Services immediately of any name and address changes.

Student's Last Name	First Name		MI	Maiden	Date of Birth
Home Address				Citizen of USA yes or no	If no, Citizen of what Country
City	State	Zip	(Area Code) Home phone	(Area Code) Cell Phone	(Area Code) Work Phone
Age	Sex	Email:		Living on the college campus as a resident. yes or no	Commuter yes or no
Participation in Intercollegiate Athletics	Yes	No	Sport		

Emergency Contact
(All students must list an emergency contact)

Name____

Address____

____
Relationship____________________________________
Home Phone_____________________________________
Work Phone_____________________________________
Cell Phone______________________________________

Allergies
_____No Known Allergies

Allergic to:	Reactions

Health Insurance Information

Insurance Co. Name:	Subscriber's Name	ID or Policy #	Group #
Insurance Co Address:			

Health Insurance is REQUIRED for Resident Students living on campus and Intercollegiate Athletes!

Please Attach A Copy of Your Insurance Card. Front and Back

Health Care Provider (Family Physician)

Name			
Address	City	State	Zip
Phone	Fax		

Family Medical History (Please check any significant medical history that pertains to your immediate family (Mother, Father or Siblings)

	Yes	No		Yes	No
Allergies			Seizures		
Mental/Nervous Disease			Tuberculosis		
Diabetes			Migraine Headaches		
Heart Trouble					

Personal History: Please comment on all yes answers in comment section or on an additional sheet.

Have You Had?	Y	N		Y	N		Y	N		Y	N
Allergies, seasonal			Diarrhea, Frequent			HIV/AIDS			Strep throat, recurrent		
Anemia			Dizziness, Fainting			Insomnia			Surgery		
Arthritis			Ear, nose, throat disorder			Kidney disorder			Appendectomy		
Asthma, chronic			Epilepsy			Menstrual Problems			Tonsillectomy		
Asthma, exercise induced			Eye Problem			Mononucleosis			Thyroid Disorder		
Back Problem			Gallbladder Disease			Paralysis			Tuberculosis		
Bronchitis, recurrent			Head Injury			Pneumonia			Tumor/Cyst		
Cancer			Headache, recurrent			Rheumatic Fever			Urinary tract infection		
Chickenpox			Heart condition/Murmur			Sexually transmitted disease					
Counseling			Hepatitis			Sinus Condition					
Depression			Hernia			Stomach Disorder					
Diabetes			High Blood Pressure								

Comments: ____

____

____

Special Needs –Dietary, Housing, Support Services to facilitate Learning: ____

____

Do you take medications? No__________Yes_____________

Medications	Dosage	Frequency	Condition

Social History: Do You?

Smoke pipe, cigar, and cigarettes? No_____ Yes______ # of packs per day_______
Chew smokeless tobacco? Yes______ No_______
Would you be interested in a smoking cessation program? Yes____No_____
History of addiction: alcohol Yes___No____ other drugs Yes____No____

Consent: I certify that this information is true and complete to the best of my knowledge. I will notify Mt. Aloysius Health Services of any changes in health information. I hereby give permission to Mt. Aloysius Health Services to provide treatment of minor illnesses and injuries, administer prescribed medications, and seek affiliate agencies for clinical practicum, fieldwork and internships. In the event of a medical emergency all of my medical and insurance information will be disclosed to ambulance personnel and the admitting hospital and my emergency contact will be notified unless otherwise stated.

X__________________________________ Signature of Student: Date: _________

X__________________________________ Signature of Parent/guardian if under 18: Date:____________

Important!

- All students must have their family physician complete the physical exam and immunization form.
- Are you a Nursing or Health Studies student going into clinical? Did you submit lab titer results, Hepatitis B dates, and sign up for CPR?
  - Contact Health Services for CPR classes and PPD testing dates and times.
  - Remember you are to receive your PPD here at Mount Aloysius College not your doctor's office.
- Are you a resident student? Did you submit a copy of your health insurance card and receive your Meningitis shot?
  - All health requirements must be completed before you can move into the dorms.
- Are you playing sports? First year athletes must receive a physical exam from your family doctor, complete an Athletic Pre-Participation Health Form, and submit a copy of your health insurance card.
- Are you a Phlebotomy student? Phlebotomy students must submit titer lab results, hepatitis B dates, and a two step PPD.

Student Physical Exam (FRONT and BACK)

Must be completed and signed by a Health-Care Provider (Family Physician)

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Name:____
Last **First** **Middle Initial** **Maiden**

Allergies				
Height Feet__________ Inches________	Weight LBS__________	Blood Pressure Pulse:	Hearing Normal_________ Abnormal_______ Explain:	Vision: Normal________ Glasses________ Contacts_______
Dental Health or Problems:				

Clinical Evaluation			**Remarks or Additional Information**
Check each item in appropriate column, at right.	**Normal**	**Abnormal**	
1. Skull, Scalp, Face, Neck,			
2. Nose and Sinuses			
3. Mouth (tongue, gingiva, teeth)			
4. Throat and Tonsils			
5. Thyroid			
6. Ears (Int. and Ext. Canals)			
7. Eyes (Pupils, conjunctiva)			
8. Lungs and chest (Include Breast)			
9. Abdomen and viscera (include hernia)			
10. Gastrointestinal			
11. Endocrine System			
12. Genitourinary System			
13. Musculoskeletal			
14. Feet (flat, pain, infection)			
15. Skin			
16. Lymphatic Glands			
17. Neuropsychiatric			

Do you have any recommendations regarding the care of this student? Yes__ No__
If yes explain____
____

Is the student now under treatment for any medical or emotional condition? Yes__ No__
Explain____
____
____

Recommendations for physical activity in, Intramurals or Intercollegiate Sports:
_____Unlimited physical activity and able to participate in sports. I certify that I have examined this student and find him/her physically able to participate in intercollegiate athletics.
_____Limited Physical Activities. Explain____
_____No Physical activities. Explain:____

Physician's signature is required on the back of this form!

Mount Aloysius College Student Immunization Record

*Name:*__________________________

*REQUIRED OF ALL STUDENTS.

All students MUST have record of all four of these immunizations or a waiver must be signed indicating medical or religious reasons why you cannot receive the immunization.

1. **Polio**: (Dates) ___________________________________Oral (OPV)_____ or Inject able (IPV)____
2. **Varicella/Chickenpox**: Dose 1 ___________ Dose 2_____________ Date of Disease:___________
3. **MMR (Measles/Mumps/Rubella)**: Dose 1 ____________ Dose 2 ________________
4. **Tetanus Diphtheria: (Within past Ten (10) years)**. Date: _______________

PPD (Tuberculin Purified Protein Derivative) Mantoux Testing

Are you a Nursing or Health Studies Student? Yes____No____
If you answered yes, **DO NOT RECEIVE YOUR PPD AT YOUR PHYSICIAN'S OFFICE.** Nursing and Health Studies Students will receive a PPD at Mount Aloysius College during the first two weeks of school. This is a mandatory requirement for clinical.

Are you a phlebotomy Student? Yes _____ No ______
If you answered yes, you are required to have a two step PPD/Tuberculin Mantoux test.
Date given:___________________ Date Read: ___________________ Results: __________________
Date given:___________________ Date Read: ___________________ Results: __________________

Are you a High Risk Student? Yes____NO___ (See statement below for definition of High Risk)
TB screening is required of all students at high risk for TB as defined by the CDC (foreign persons from high prevalence countries, persons with compromised immune systems, close contacts of infectious TB cases.) If you answered yes you are considered a high risk student and you are required to receive a PPD. All other student who are not high risk, a PPD is recommended but not required.
Date: _____________ Results: _____________
If positive, was chest x-ray taken? Date_____________ Results_____________

RESIDENT STUDENTS:

****REQUIRED by Pennsylvania Law for ALL students living in dormitories/residence halls.**

Meningococcal Vaccine: ______________________________(M/Y) or signed waiver (See Vaccine Information and Waiver Record)

NURSING AND HEALTH STUDIES STUDENT REQUIREMENTS:

(Physical Therapy Assistance, Surg Tech, Medical Assistance, Medical Laboratory Technology, Medical Imaging/Ultrasonography, Phlebotomy)

- **Hepatitis B:** Dose 1_______Dose 2______Dose 3______
- **Titers for Varicella, Rubella, Rubeola, and Mumps (Clinical Requirement)**

Titers are labs drawn to determine antibodies in your blood for immunity to a particular disease. If your titers indicate that you are not immune or equivocal you will need to receive a booster for that which you are not immune. Lab results and immunization booster must be submitted 6 weeks before the beginning of classes so that they do not interfere with PPD testing for students going into clinical.

****Students Must Submit a Copy of the Titer Lab Results. This is a clinical requirement . The results must be on file with Health Services****

Varicella/Chickenpox
Immune______Not Immune_____Equivocal_______ Vaccine dates if not immune: Dose#1________Dose#2___________
Mumps
Immune______Not Immune_____Equivocal_______ Vaccine date if not immune________
Rubeola (Measles)
Immune______Not Immune_____Equivocal_______ Vaccine date if not immune________
Rubella (German Measles)
Immune______Not Immune_____Equivocal_______ Vaccine date if not immune________

Nursing and Health Studies Students who are going into clinical will receive a PPD at Mount Aloysius College during the first two weeks of school. The PPD cannot be given if a live virus (MMR or Varicella) vaccination is given within that 4-6 week time frame. If a student needs to be vaccinated and it is less than 4 weeks before school begins, please refrain from giving the live virus until after the PPD is given and before their clinical rotation begins.

I have reviewed the student's health information, examined the student and certify there is no medical evidence, which would preclude the student's participation in college activities including student clinical practicum.

Signature of Licensed Health-Care Practitioner:

X___________________________________Print Name or Name of Practice___________________________________Date_________

Street Address____

City_______________________________ State________Zip__________ Phone __________________

Mount Aloysius College

Vaccine Waiver Record

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Office Use Only
Date Received
____
Date Entered
____

Make copies for your records

Vaccine Waiver Record is for exemption of medical or religious reasons only.

Student's Name:______________________________

Student ID#:____________________________

Date of Birth:______________________________ Program:____________________________

I have reviewed the information on the risks associated with vaccine preventable diseases and the availability and effectiveness of the vaccines. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccines required. However, I choose not to be vaccinated at this time. By signing a waiver I cannot hold Mount Aloysius College responsible if I am exposed to any communicable diseases. I understand the vaccines will be available in the Health Services Office or other Health Care Facilities, should I decide to get them at a later date.

I choose not to receive the following vaccine(s): Please check all that apply at this time if you do not want this vaccination.

- ❑ Tetanus-Diphtheria
- ❑ MMR (Measles, Mumps, and Rubella)
- ❑ Varicella (Chicken Pox)
- ❑ Influenza
- ❑ Hepatitis B
- ❑ Meningococcal (Meningitis)
- ❑ PPD
- ❑ Polio

MEDICAL EXEMPTION

The physical condition of the above named student is such that immunization would endanger life or health.

X____ Date:________________________
(Licensed Health-Care Practitioner)

State your reason for requesting your medical or religious exemption.

____
____
____

Signature of Student (or parent/guardian if under 18)
X____ Date:_________________________

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MENINGITIS ON CAMPUS

Know Your Risk
Learn About Vaccination

Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, freshmen living in dorms are found to have a six-fold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningitis and vaccination.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – types A, C, Y and W-135. Protective antibody levels may be achieved within 7-10 days after vaccination and provides protection for approximately 3 to 5 years. As with any vaccine, it may not protect 100% of all susceptible individuals.

Senate Bill 955 states that colleges shall prohibit a student from residing in a dormitory unless the student has received a one-time vaccination against meningococcal disease. A student is exempt if they sign a written waiver stating that they have received and reviewed information provided by the college and have chosen not to be vaccinated.

- What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.
- How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with and infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
- What are the symptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
- Who is at risk? Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

For more information: To learn more about meningitis and the vaccine visit Mount Aloysius College Health Services Office. You can also visit the websites of the Center for Disease Control and Prevention (CDC) at www.cdc.gov/ncidod/dbmd/diseaseinfo and the American College Health Association at www.acha.org.
The vaccine is available to all students through Health Services. Please visit (St. Joe's Hall Room 100-102) or call (814-886-6515) to make an appointment. Waiver forms are also available in Health Services, but we strongly urge you to receive the vaccine if you haven't done so already.

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MENINGOCOCCAL VACCINE WAIVER FORM

Must be completed by all dormitory students

According to the Pennsylvania College and University Vaccination Act of July 2002 (Senate Bill 955), students who reside in a dormitory must receive a vaccination against meningococcal disease. A student is exempt from the vaccination requirement if the college provides detailed information on the risks associated with meningococcal disease, the availability and effectiveness of the vaccine and the student signs a written waiver. If the student is a minor, the student's parent or guardian must sign the waiver.

PLEASE CHECK ONLY ONE OPTION

☐ I have received the meningitis vaccine on _______________ (mm/dd/yy)

☐ I have received and reviewed information on the risks associated with meningococcal disease and the availability and effectiveness of the meningococcal vaccine. I have chosen NOT to be vaccinated against meningococcal disease at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at Health Services or elsewhere.

Print Name: _____________________________ **Date:** _____________________________

If student is 18 years of age or older
Signature of Resident Student: _________________________________

If student is under 18 years of age
Signature of Parent/Guardian: __________________________________

PLEASE COMPLETE AND RETURN TO HEALTH SERVICES PRIOR TO MOVING INTO THE RESIDENCE HALL!

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Annual Pre-Participation Athletic Medical History
(To be completed yearly by students participating in sports)

Name: ______________________________ **Sport:** ______________________________

Chronic Illnesses: ____

Recent Acute Illnesses: ____

Past Hospitalizations: ____

Past Surgeries: ____

Past Injuries: ____

Allergies: ____
(Drug, Food, Environmental)
Medications: ____
(Over the counter, Prescription, Vitamins)
Prior limitations placed on sports participation: _______________________________________

THE NEXT 2 APPLY TO FEMALE ATHLETES ONLY:
Pregnancies: ____
Menstrual History: ____
(Age of menses, duration, frequency)
Check all that apply (Male and Female athletes):

- ❑ Previous concussion or loss of consciousness
- ❑ Syncope or near syncope with exercise
- ❑ Symptoms of exercise-induced bronchospasm
- ❑ Loss of paired organ function (eye, kidney, lung, testicle)
- ❑ Excessive fatigue
- ❑ Exertion chest pain
- ❑ Excessive exertion shortness of breath
- ❑ History of heat related illness
- ❑ History of cardiac disease or symptoms
- ❑ History of heart murmur
- ❑ History of high blood pressure
- ❑ Possible exposure to Tuberculosis (TB)
- ❑ Family history of sudden death (under age 50 from non-traumatic cause)
- ❑ Family history of heart disease
- ❑ Family history of Marfan syndrome

Signature: ____ **Date**: ________________