Name: _____

Cell : (Student)_____

Marywood

UNIVERSITY

# STUDENT HEALTH SERVICES

**Health History**
**Physical Examination**
**Immunization Record**

It is **MANDATORY** for **ALL RESIDENT STUDENTS**
to submit this form in its entirety
**BEFORE** the beginning of the semester.

**Please return completed form to:**

Marywood University Health Services
2300 Adams Avenue
Scranton, PA 18509

Lead On.

Marywood University Health Services
Scranton, PA 18509
(570) 348-6249 • Fax (570) 961-4735

# HEALTH HISTORY

You have been accepted to Marywood University. This information is CONFIDENTIAL and is to be used strictly by the Health Services as an aid in providing health care. No information will be released without your knowledge and written consent.
PLEASE COMPLETE THIS PORTION BEFORE GOING TO YOUR HEALTH PROVIDER.

| Last Name | First | Middle | Date of Birth | I.D. Number |
|---|---|---|---|---|
| Home Address | City/Town | State | Zip Code | Phone Number |
| Next of Kin to be Contacted in Emergency | | | Relationship | Phone Number |
| Business Address | | | | Business Phone Number |

Sex: _____ Marital Status:_____ Major:_____

**Health Insurance Policy:**
Company _____
Policy # _____
Name of Insured: _____

| FAMILY HISTORY | | | | | |
|---|---|---|---|---|---|
| | Age | Health | Occupation | Age at Death | Cause of Death |
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| Sisters | | | | | |

Personal Medical History. Have you ever had…? Check yes if applicable.

| HAVE YOU HAD? | YES | | YES | | YES | | YES |
|---|---|---|---|---|---|---|---|
| Scarlet Fever | | Asthma | | Fainting | | Hepatitis | |
| Measles | | History of Strep | | Surgery | | Infectious Mono | |
| German Measles | | Throat Infection | | Appendectomy | | Kidney Disease | |
| Mumps | | Bleeding Tendency | | Tonsillectomy | | Urinary Tract Infection | |
| Chicken Pox | | Sinusitis | | Hernia Repair | | Skin Disorder | |
| **Allergy** | | Dental Problems | | Other | | Stomach-Intestinal Problems | |
| Penicillin | | Diabetes | | Emotional Problems | | Colitis | |
| Sulfa | | Hypoglycemia | | Epilepsy | | Ulcer | |
| Serum | | Disease of Bone | | Seizure Disorder | | Diarrhea Recurrent | |
| Foods | | Joint injury | | Head Injury with | | Substance Abuse -Alcohol/Drugs | |
| Insects | | Knee-Back | | Unconsciousness | | Tuberculosis | |
| Other (specify) | | Eye,Ear,Nose | | Headaches (Migraine) | | Thyroid Disorder | |
| Anemia | | Throat Problem | | Heart Disease - | | Tumor - Cancer - Cyst | |
| High Blood Pressure | | Eating Disorder | | Mitral Valve prolapse | | Sexually Transmitted Disease | |
| Chronic Cough | | Anorexia | | Murmur | | Females: Irregular or | |
| Bronchitis | | Bulimia | | Rheumatic Fever | | Disabling Period | |

Are you currently taking any prescribed medications? Yes _____ No _____
If yes, please list with dosage required: _____

***OPTIONAL:** Do you require accommodation to a disability? If so, please give specifics on the accommodations required in the space below or attach letter of explanation. We would like to share information with the appropriate offices on campus. Please check this box if we have your author ization to do so. ❑

**Authorization for Treatment:** I hereby authorize the Marywood health provider to treat _____ for any illness or accident deemed necessary by the university health provider. I understand that in case of serious medical emergency, every effort will be made to contact me. I will be responsible for all bills incurred.

Signature of Student Date Signature of Parent or Guardian Date

**I authorize release of relevant medical information or records to my parents/guardian. ❑ Yes ❑ No**

Signature of Student Date

# PHYSICAL EXAMINATION

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****

| Last Name | First | Middle | Sex |
|---|---|---|---|
| Blood Pressure ____/____ | Pulse ____/____ | Height _____ | Weight _____ |
| Visual Acuity | (R) 20 / _____ | (L) 20 / _____ | |

## SYSTEMS REVIEW

| | Normal | Abnormal | Describe Abnormalities |
|---|---|---|---|
| Skin | _____ | _____ | _____ |
| HEENT | _____ | _____ | _____ |
| Lymph Nodes | _____ | _____ | _____ |
| Neck | _____ | _____ | _____ |
| Heart | _____ | _____ | _____ |
| Lungs | _____ | _____ | _____ |
| Respiratory | _____ | _____ | _____ |
| Gastrointestinal | _____ | _____ | _____ |
| Genitourinary | _____ | _____ | _____ |
| Reproductive | _____ | _____ | _____ |
| Endocrine | _____ | _____ | _____ |
| Musculoskeletal | _____ | _____ | _____ |
| Neuro/Psych | _____ | _____ | _____ |

## GENERAL COMMENTS:

Is there any loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals)

Unlimited _____ Limited _____ Explain: _____

_____

Do you have any recommendations regarding the care of this patient? _____

_____

Is this patient now under treatment for any medical or emotional condition?_____

_____

**This patient is free of communicable disease** Yes ❑ No ❑

**HEALTH PROVIDER'S SIGNATURE** _____**MD ❑ DO ❑ PA-C ❑ NP ❑**

**DATE** _____

Health Provider's Name (please print) _____

Address: _____

Telephone Number: (_____) - _____ Fax: (_____) - _____

# IMMUNIZATION RECORD

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****
**Day, month and year must be completed.**

_____
Last Name First Middle

**IMMUNIZATIONS MUST BE UPDATED AS SPECIFIED BELOW.**

**A.** TETANUS-DIPHTHERIA

1. ❑ Completed primary series of tetanus-diphtheria immunizations . . . . . _____/_____/_____
2. ❑ Received diphtheria, pertussis, tetanus booster within the last 10 years . . . . . _____/_____/_____

**B.** M.M.R. (Measles, Mumps, Rubella)

1. ❑ Dose 1 - Immunized at 12 months . . . . . _____/_____/_____
2. ❑ Dose 2 - Immunized at 4-6 years and at least one month after first dose . . . . . _____/_____/_____

**C. Hepatitis B Vaccine** (three doses or a positive Hepatitis B surface antibody titer meets the requirement).

❑ Dose 1 . . . . . _____/_____/_____
❑ Dose 2 . . . . . _____/_____/_____
❑ Dose 3 . . . . . _____/_____/_____

**D. Varicella**

❑ History of disease . . . . . _____/_____/_____
❑ Vaccine Dates: Dose 1 ..... _____/_____/_____ Dose 2 . . . . . _____/_____/_____

**E. Tuberculosis Screening** (PPD regardless of prior BCG inoculation). A two step, within a 3-week interval, is required for all Nursing, Nutrition/Dietetic, and Physician Assistant Students in **sophomore year**.

1. PPD (Mantoux) Test within the past year (**Tine or monovac not acceptable**).
   PPD #1 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
   PPD #2 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
2. **Positive PPD – Chest x-ray required. Must submit a copy of the chest x-ray reading.**

**F. Polio**

❑ Completed primary series of polio immunizations: _____Yes _____ No
❑ Type of vaccine: _____ Oral _____ Inactive _____ E-IPV
❑ Last Booster . . . . . _____/_____/_____

**G. Meningitis** – Pennsylvania law mandates that ALL students living in university owned housing be immunized or sign a waiver after receiving information on the disease and vaccine.

❑ Vaccine . . . . . _____/_____/_____

**H. Influenza** . . . . . _____/_____/_____

**HEALTH CARE PROVIDER**

Name: _____ Address: _____

Signature: _____ **MD ❑ DO ❑ PA-C ❑ NP ❑** Phone: ( ) _____