



Student Health Services

Phone: 215-572-2966 Fax: 215-881-8787

2010 – 2011 Health Record

The Health Record is a confidential document for the use of Student Health Services only. After completion of the entire form, please return it to Student Health Services. All full-time undergraduate students and full-time Physical Therapy (PT), Physician Assistant (PA), Genetic Counseling (GC), Forensic Science (FS) and International Peace and Conflict Resolution (IPCR) graduate students are required to complete this form. In order to access Student Health Services, other than on an emergency basis, a completed **Health Record** must be on file.

IDENTIFICATION

Name (Last, First, Middle)

Home Address (number and street)

City State Zip

Home Telephone # / Student Cell Phone #

Social Security # Birth Date

REGISTRATION DATA

(Circle appropriate choice)

Undergraduate: 1st year 2nd year 3rd year 4th year

Gender: Male Female

Residential Commuter

Graduate Program: PT PA GC IPCR FS

Full Time Part Time Transfer

EMERGENCY CONTACT INFORMATION

Person to be contacted in case of emergency: Name Relationship

Home Address City State Zip Home Phone Cell Phone

Work Address City State Zip Work Phone Cell Phone

HEALTH INSURANCE INFORMATION

Name of Insurance Company

Customer Service Phone Number

Group Number

Name of Policy Holder

Identification Number

Prescription Plan? Yes No (Circle One)

Please provide copy (front & back) of Insurance card and Prescription card

ARCADIA UNIVERSITY

To the Student: YOU HAVE BEEN ACCEPTED TO ARCADIA UNIVERSITY. Information you provide will not be used to influence your situation at the University; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Student Health Services and will not be released to anyone without your knowledge and consent.

REPORT OF MEDICAL HISTORY

Please complete this page before going to your health care provider for the physical examination. Your health care provider must complete the Physical Examination and Immunization records.

LAST NAME (Print) FIRST NAME MIDDLE INITIAL SOCIAL SECURITY NO.

FAMILY HISTORY

	Age	State of Health	Occupation	Age/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

Have any of your relatives ever had any of the following:

	Yes	No	Relationship
Diabetes			
Heart Disease/Stroke/High Blood Pressure			
Cancer			
Asthma/Allergies			
Tuberculosis			
Alcohol/Drug Problem			
Depression			

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS – Please comment on all positive answers below (Use additional sheet if necessary)

Have you had?	Yes	No
Chicken Pox		
Measles		
German Measles		
Mumps		
Mononucleosis		
More than 10 lb. weight gain or loss in past year		
Females: menstrual problems		

Have you had?	Yes	No
Dental problems		
Eye problems		
Ear, nose, throat problems		
Asthma		
Seasonal Allergies		
Other medical problems (list):		

Have you had?	Yes	No
Head injury or Concussion		
Epilepsy/seizures		
Migraines		
Anxiety or depression		
Sleep difficulty		
Eating disorder		
Alcohol/drug problem		
Learning disability		

Have you had?	Yes	No
Diseases/injury of joints		
Back problems		
Heart trouble/high blood pressure		
Stomach/intestinal problems		
Liver or kidney problems		
Skin problems		
Tumors or cysts		
Cancer		
Diabetes		

SOCIAL HISTORY (Comment below or use additional sheet if necessary)	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes, cigars or use smokeless tobacco?		
Do you take medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Explain)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Explain) Have you been hospitalized for any of the above?		
Have you had any significant illness or injury for which you have been treated or hospitalized other than already mentioned? (Explain)		
Do you have any additional information regarding your health, family history, or other matters:		

DRUG ALLERGY	Type of Reaction	Type of Reaction
<input type="checkbox"/> None		<input type="checkbox"/> Sulfa
<input type="checkbox"/> Codeine		<input type="checkbox"/> Penicillin or Ampicillin
<input type="checkbox"/> Other Please Specify:		<input type="checkbox"/> Food allergy – please specify

ALLERGY INJECTIONS:

You may visit the website to download a consent form and a copy of our policy regarding allergy injections at www.arcadia.edu/student/ and check the Health Services tab on the left of the webpage. Alternatively you can call the Student Health office (215-572-2966) to receive the form by mail.

Student's Signature

Health Care Provider's Signature (Acknowledging Review)

Date

REMARKS OR ADDITIONAL INFORMATION (Use additional sheet if necessary)

PHYSICAL EXAMINATION

TO THE EXAMINER: PLEASE REVIEW THE STUDENT'S HISTORY AND COMPLETE THE PHYSICAL EXAMINATION AND IMMUNIZATION RECORD. PLEASE COMMENT ON ALL POSITIVE ANSWERS.

LAST NAME _____ FIRST NAME _____ MIDDLE _____
 SEX: M F

Blood Pressure _____ Pulse _____ Height _____ inches Weight _____ lbs.

Are there abnormalities in the following systems? Describe fully. Use additional sheet if needed.
Please comment on all positive findings.

	Normal	Abnormal / Comments
Head, Ears, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurologic		
Skin		
Psychiatric		

Is the patient now under treatment for any medical or emotional condition? No _____ Yes _____ (explain)

Is the patient currently taking any medication on a regular basis? No _____ Yes _____ (explain)

If yes, list medications: _____

Is there a loss or seriously impaired function of any organ? No _____ Yes _____ (explain)

Recommendations for physical activity:
 (Intercollegiate Athletics, Intramurals, Physical Education)
 Unlimited _____ Limited _____

Explain: _____

Do you have any further recommendations for the care of this student? Yes _____ No _____

Explain: _____

HEALTH CARE PROVIDER _____

NAME _____

ADDRESS _____

_____ **PHONE** _____

SIGNATURE _____ **DATE** _____



IMMUNIZATION RECORD

NAME _____ Date of Birth: _____ last 4 of SS# _____

Note that the immunizations listed below are **MANDATORY**. Specify the personal, medical or religious reason for any immunization that is not given. Documentation of immunity via **TITERS** is **ACCEPTABLE**.

HEALTH CARE PROVIDER to fill out this section of required vaccines

VACCINE	DATE
DPT Series (Date series completed)	
Td/TDAP/Adacel (Circle) (Booster in last 10 years)	
OPV (polio) Series Date, series and booster completed or titer	_____ Fill in all 4 dates please
MMR # 1 (if born after 1956) 2 doses or immune titer	
MMR # 2 2 doses or immune titer	
Hepatitis B # 1	
Hepatitis B # 2	
Hepatitis B # 3	
Hep B Surface ANTIBODY	Date _____ <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
Varivax vaccine # 1 (chickenpox vaccine if born after 1979 or not born in the USA)	
Varivax vaccine # 2	
Varivax vaccine TITER Recommended for proof of immunity Date of disease: _____	_____ Titer date and result
Meningococcal (RESIDENTIAL STUDENTS) (A/C/Y/W-135) or signed WAIVER	
Tuberculosis Testing (PPD) within the last 6 months* required regardless of prior BCG inoculation) Date: Result: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Induration _____ mm Dates of INH therapy: _____ - _____	If required: Chest X-Ray Date: _____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ Provider Signature

Meningitis Vaccine Waiver

___ **DECLINE:** I have read and understand the above information about meningitis and the benefits of immunization FOR RESIDENTIAL STUDENTS. I decline the meningitis vaccine at this time. I understand in declining this vaccine, I continue to be at risk for this serious disease. **Incoming students may waive this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization.**

Print name _____

Signature of student _____ Date _____

Signature of Parent _____ Date _____
(If student is 17 years of age or younger)

PA/PT students only:
MUST have 2-step PPD (2 wks apart) within the last 6 months*
required regardless of prior BCG inoculation)

Date: _____

Result: _____ Induration mm

Date: _____

Result: _____ Induration mm

Healthcare Provider Information: (Physician, Nurse Practitioner, etc.)

Name of Provider (Please Print)

Phone Number/Fax number

Signature of Provider: (I have informed my patient of any immunization updates needed for completion of above required immunizations)

Address

PLEASE MAKE A COPY OF THIS ENTIRE FORM (FOR YOUR RECORDS) BEFORE SUBMITTING AND RETURN ORIGINAL FORM TO STUDENT HEALTH CENTER ONLY.