



ARCADIA UNIVERSITY ATHLETICS

Student Health Services

Phone (215) 572-2966 Fax (215) 881-8787

Health Record

Instructions and Information

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.

The **Identification Information** and **Health History** are to be provided by the student. The **Physical Exam** and **Immunization Record** is to be completed by your health care provider. Take special note of the immunization section. **These immunizations are required**. If there are personal, religious or medical reasons against immunization, a signed statement by the student, medical provider or clergy is required for exemption.

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB	SOCIAL SECURITY #
HOME ADDRESS	CITY	STATE	ZIP CODE	CELL PHONE
PARENT / GUARDIAN	Home phone	Cell Phone		

Registration Data: (circle appropriate choice)

Undergraduate: 1st year 2nd year 3rd year 4th year Transfer Full-time Part-time
Graduate program: PT PA GC IRCR FS
Residential Status: University housing Commuter **Gender:** Male Female

HEALTH INSURANCE INFORMATION

Name of Insurance Company	Customer Service Phone Number
Group Number	Identification Number
Name of Policy Holder	Prescription Plan? Yes No circle one

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

REPORT OF MEDICAL HISTORY

Please answer all of the following questions	Yes	No
Have you been hospitalized or had surgery in the past 12 months (please list)		
Has a doctor ever denied or restricted your participation in physical activity for any reason? (please explain)		
Do you have an ongoing medical condition such as asthma or diabetes? (list)		
Are you currently taking any prescription or non-prescription medications? (list below)		

Have you been knocked unconscious at anytime during the last 12 months?		
Do you smoke or use tobacco products?		
Do you drink alcohol?		

Have you ever had or do you now have any of the following conditions?								
	Yes	No		Yes	No		Yes	No
A heart murmur			Eye Injury			Ever have injuries to the following?		
High blood pressure			Impaired Vision				Neck	
A heart infection			Dental Problems			Shoulder		
Chest Pain			Missing Teeth			Arm or Elbow		
Heart Racing or Skipping			Do You Wear:			Wrist or fingers		
Marfan's Syndrome			Glasses or Contacts			Back		
Dizziness or Fainting			Neurological Injuries			Groin		
Breathing Problems			-Concussion			Thigh		
Heat Exhaustion or Heat Stroke			-Skull Fracture			Knee		
Frequent Headaches			- Loss of Consciousness			Lower Leg		
Mononucleosis			- Amnesia			Ankle or Foot		
Anemia			-Seizure Disorder			Allergies		
Chronic Cough			Skin Conditions such as:			- Medications		
Lung Problems			-MRSA			-Insects		
Stomach / Intestinal Problems			-bacterial infection			-Latex		
Spleen Injury			Eating Disorder such as:			-Other Allergies		
Hernia			-Anorexia			Females only:		
Seizure Disorder			-Bulimia			Changes in menstrual		
Urinary Problems			Are you missing one of these organs?			Are you currently pregnant?		
Ear Injury			-Lung			Do you have any medical conditions not listed above? List below		
Hearing Difficulty			-Kidney					
Nose Injury			-Testicle					
Frequent Nose Bleeds								

FAMILY HISTORY

Have any of your relatives had the following?

Condition	Yes	No	Relationship	Explain
Sudden Death Before age 50?				
Diabetes				
Heart Disease				
Stroke				
High Blood Pressure				
Cancer				
Marfan's Syndrome				
Asthma / Allergies				
Tuberculosis				
Alcohol / Drug Problems				
Depression				

I certify that the answers to the questions above are correct and true.

_____	_____	_____	_____
Student-Athlete Signature	Date	Health Care Providers Signature (Acknowledging Review)	Date

ARCADIA UNIVERSITY ATHLETIC CLEARANCE FORM

NCAA policies recommends that any student who intends to participate in intercollegiate athletic activities must have on file at the school a record of having passed a complete physical examination upon initial entrance into the school's intercollegiate athletic program. Arcadia University requires their athletes to complete a heart and lung screening and medical history form yearly. All athletes must have a completed health record on file in the Student Health Services Center ***prior to participation.***

Name _____ DOB _____ Sport _____

Height _____ Weight _____ Blood Pressure _____ / _____ Pulse _____

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

_____ **Has Satisfactorily** completed the examination to participate in athletics at Arcadia University.

_____ **Has Not** satisfactorily completed the examination and is not cleared to participate in athletics at Arcadia University. The following findings should be further evaluated prior to participation clearance:

Name of physician or nurse practitioner

Date

Signature of physician or nurse practitioner

Address

Phone

I the undersigned certify that the answers to the questions above are correct and true. I also understand that passing the physical exam does mean that I am physically qualified to engage in athletics, but that the examiner did not find a medical reason to disqualify me.

Student-Athlete Signature

Date

IMMUNIZATION RECORD

NAME _____ Date of Birth: _____ 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**.

TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

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	
MMR # 1 (Mumps, Measles, Rubella) 2 doses or immune titer	
MMR # 2 (Mumps, Measles, Rubella) 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)	
Varivax vaccine # 2 (chickenpox vaccine)	
Varivax vaccine TITER (chickenpox titer)	
Meningococcal (RESIDENTIAL STUDENTS) (A/C/Y/W-135) or signed WAIVER	

<p>Recommended Immunization for Females HPV (Human Papilloma Virus)</p> <p>3 doses for women (through age 26)</p> <hr/> <p><u> #1 (date) #2 (date) #3 (date) </u></p>
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<p>Meningitis Vaccine Waiver</p> <p>___ 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.</p> <hr/> <p>Print name _____</p> <hr/> <p>Signature of student _____ Date _____</p> <hr/> <p>Signature of Parent _____ Date _____ (If student is 17 years of age or younger)</p>

<p>Tuberculosis Testing (PPD) within the last 6 months* required regardless of prior BCG inoculation)</p> <p>Date:</p> <p>Result: <input type="checkbox"/> Neg <input type="checkbox"/> Pos</p> <p>Induration _____ mm</p> <p>Dates of INH therapy:</p>	<p>PA/PT students only: MUST have 2-step PPD (2 wks apart) within the last 6 months* required regardless of prior BCG inoculation)</p> <p>Date:</p> <p>Result: _____ Induration mm</p> <p>Date:</p> <p>Result: _____ Induration mm</p>	<p>If required: Chest X-ray</p> <p>Date: _____</p> <p>Results:</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Abnormal</p> <p>_____ Provider signature</p>
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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 Rev: 01/08