



Masters of Public Health (MPH) Graduate Student Health Record 2019-2020

450 South Easton Road, Glenside, PA, 19038 | Phone (215) 572-2966 | Fax (215) 881-8787 | Email SHS@arcadia.edu

This health record is a confidential document for the use of Student Health Services (SHS) only. After completion of both forms by a health care provider, please enter the immunizations and upload the forms to the SHS Patient Portal located on your My Arcadia homepage: <http://arcadia.medicatconnect.com/>.

ATHLETES MUST COMPLETE THE GRADUATE STUDENT HEALTH RECORD IN ADDITION TO ATHLETIC FORMS.

Name (Last, First, Middle)

Date of Birth (MM/DD/YYYY)

Home Address

City

State

Zip Code

Arcadia ID Number

Student Cell Phone Number

Will you be living on campus? Yes No Unsure

Vaccination History

All forms and lab results must be uploaded for verification. If unable to verify Immunization Status, titers are required. Ask your healthcare provider for measles, mumps, rubella, varicella, and hepatitis B titers if dates are unobtainable.

Description	Date	Value
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*Tuberculosis Test (Within 1 Year)

A. TB IGRA Blood Test <i>T.SPOT or QuantiGold</i>	_____	+ _____ - _____
OR		
B. Tuberculosis PPD	_____	+ _____ - _____
Date Placed	Date Read	

*MMR Vaccination

A. MMR Vaccination Series	
1. MMR Vaccine #1	_____
2. MMR Vaccine #2	_____
OR	
B. MMR Titer	
1. Measles Titer Results	_____
2. Mumps Titer Results	_____
3. Rubella Titer Results	_____

*Varicella Vaccination

A. Varicella Vaccination Series	
1. Varicella Vaccine #1	_____
2. Varicella Vaccine #2	_____
OR	
B. Varicella Titer	_____ + _____ - _____
OR	
C. Varicella Disease Date	_____

*Tdap (Within past 10 Years) _____

*Meningitis Vaccination (*Required only if living on Campus)

1. Meningitis Initial Dose	_____
2. Meningitis Booster after 16yo	_____

Description	Date	Value
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Hepatitis B Vaccination

A. Hepatitis Vaccination Series	
1. Hepatitis B Vaccine #1	_____
2. Hepatitis B Vaccine #2	_____
3. Hepatitis B Vaccine #3	_____
OR	
B. Hepatitis B Positive Titer	_____ + _____ - _____
(Positive surface antibody Results)	

Hepatitis A Vaccination

1. Hepatitis A Vaccine #1	_____
2. Hepatitis A Vaccine #2	_____

Polio Vaccination

1. Polio Vaccine #1	_____
2. Polio Vaccine #2	_____
3. Polio Vaccine #3	_____
4. Polio Vaccine #4	_____

Please either have your Primary Provider validate these immunizations below, OR submit records to validate your immunizations via your Patient Portal.

Name of Provider (Please Print)

Signature of Provider

*Immunizations required by Student Health Services and ACHA guidelines



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Submitting your Records to the Patient Portal

Please submit your immunization records, physical, and any documentation needed to your Patient Portal. You can find the patient portal on your My Arcadia homepage, shown as a stethoscope icon.

Patient Portal Compliance Check List:

- Submit Immunization Form** (that has been signed off by your physician or with medical records for validation)
- Enter the Dates into slot provided on the Immunization Tab**
- Submit Medical History and Physical Form**
- Waive or Enroll Arcadia Insurance Coverage**
- Submit a copy of insurance**
- Follow up and submit necessary paperwork with your Graduate Department**

IMPORTANT HEALTH INSURANCE INFORMATION

Arcadia University requires every full time student to have health insurance. Arcadia University has contracted with **United Healthcare** at an approximate rate of \$2810.00 annually. Charges are automatically applied to tuition. Students must “waive out” or “enroll” in health insurance.

If a student waives out **and** has provided insurance coverage information, a refund will be applied to their account within 7-10 business days.


United Healthcare’s website opens July 1st, 2019.

How to waive coverage or enroll online?

Go to www.firststudent.com, select “Find your school”, and select ‘Arcadia University’. On the left side of the page, select “Waive your school’s insurance” **or** “Enroll now”. Enter your date of birth and your Arcadia ID. To waive, you must enter your current health insurance information. You will receive a confirmation email after you complete the process.

Health Insurance Questions?

Call RCM&D at 1-800-346-4075 ext. 1452

Enter health insurance information via the SHS patient portal when entering your health forms. To enter your health insurance, scroll to the umbrella icon  .



Personal Medical History

450 S Easton Road, Glenside, PA 19038 | Phone: (215) 572-2966 | Fax: (215) 881-8787

Last Name _____ First Name _____ MI _____ Date of Birth _____ Sex: M F

Preferred Name _____ Gender Identity _____ Pronouns _____

Residency: On campus Off Campus Unsure _____ Cell Phone _____

Allergies

Are you allergic to any medications? Yes No
Please List: _____

Are you allergic to Latex? Yes No

Are you allergic to any foods? Yes No
Please List: _____

Medications

List all Medicines and supplements you take:

Medicine or Supplement	How much?	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Personal Health History

Have you EVER HAD, or do you have, any of the following? Check EACH item, if yes, specify by number and explain:

- | | No | Yes | | No | Yes |
|--|--------------------------|--------------------------|---------------------------------------|--------------------------|--------------------------|
| 1. Skin problems or chronic rash | <input type="checkbox"/> | <input type="checkbox"/> | 22. Broken bones | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Eye problems | <input type="checkbox"/> | <input type="checkbox"/> | 23. Bone or joint problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Hearing loss or ear problems | <input type="checkbox"/> | <input type="checkbox"/> | 24. Arthritis/gout | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Chronic cough | <input type="checkbox"/> | <input type="checkbox"/> | 25. Back pain/injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Asthma | <input type="checkbox"/> | <input type="checkbox"/> | 26. Neck pain/injury | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> | 27. Loss of limb | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Lung problems | <input type="checkbox"/> | <input type="checkbox"/> | 28. Severe headaches | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Tuberculosis or positive TB skin test | <input type="checkbox"/> | <input type="checkbox"/> | 29. Dizziness or fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | 30. Epilepsy or seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Heart trouble/attack | <input type="checkbox"/> | <input type="checkbox"/> | 31. Severe weakness or tiredness | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Palpitations/irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> | 32. Depression or anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Heart murmur | <input type="checkbox"/> | <input type="checkbox"/> | 33. Emotional or psychiatric problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | 34. Drug or alcohol dependency | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Stroke or paralysis | <input type="checkbox"/> | <input type="checkbox"/> | 35. Eating disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Stomach or intestinal problem | <input type="checkbox"/> | <input type="checkbox"/> | 36. Bleeding or blood disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Liver disease/hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | 37. Immune suppression | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> | 38. Chronic/recurrent infection | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Unintentional weight change | <input type="checkbox"/> | <input type="checkbox"/> | 39. Tumor/cancer | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | 40. Anemia | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Shoulder/elbow/wrist/hand pain | <input type="checkbox"/> | <input type="checkbox"/> | 41. Diabetic | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Numbness/tingling of arms or hands | <input type="checkbox"/> | <input type="checkbox"/> | 42. Any other illness not listed | <input type="checkbox"/> | <input type="checkbox"/> |

If yes, Specify by number: _____

Past Surgical History

Have you ever had surgery? Y N

If yes, Please List:

Type	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____



PHYSICAL EXAMINATION

To be filled out by your Health Care Provider

 Last Name First Name MI Date of Birth Sex: M F
 Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. BMI _____

Review of systems

(Check "✓" if normal)

- | | |
|---|--|
| <input type="checkbox"/> General Wellness: _____ | <input type="checkbox"/> Neurological: _____ |
| <input type="checkbox"/> Eyes: _____ | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Skin: _____ | <input type="checkbox"/> Reproductive/Urinary: _____ |
| <input type="checkbox"/> Ears, Nose, Throat: _____ | <input type="checkbox"/> Thyroid/Endocrine: _____ |
| <input type="checkbox"/> Stomach/Digestion: _____ | <input type="checkbox"/> Psychiatric: _____ |
| <input type="checkbox"/> Lungs/ Breathing: _____ | <input type="checkbox"/> Blood/Lymph: _____ |
| <input type="checkbox"/> Heart/Circulation: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Muscle/Joints/Bones: _____ | _____ |

	No	Yes
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Metabolic/Endocrine		
Musculoskeletal		
Neurologic		
Skin		

Allergies: _____

If the patient currently taking any medication on a regular basis? No Yes

Does the patient have a specific Diet? No Yes

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

Please note that Student Health Services **cannot** initiate, renew, or refill **psychiatric medication**. Please contact the Counseling Services at (215) 572-2967 for information on continuation of psychiatric care while living on campus.

 Signature CRNP/MD

 Printed Name

 Date

Arcadia University Student Health Services
 450 South Easton Road
 Glenside, PA 19038
 215-572-2966 (phone)
 215-881-8787 (fax)

Veterans: Your Discharge Physical is Acceptable
 Log onto www.ebenefits.va.gov for more information on how to access your health records.