Student Health Services (SHS)
Phone (215) 572-2966 Fax (215) 881-8787
450 South Easton Rd., Glenside, PA 19038

2019-2020 International Student Health Record

The Health Record is a confidential document for the use of Student Health Services only. After completion of the entire form by a health care provider, please return it to Student Health Services.

All full-time international students are required to complete this form.

_____ **Undergraduate**: 1st year 2nd year 3rd year 4th year
Name (Last, First, Middle)

_____ **Gender: Male** _____ **Female** _____
Home Address (number and street)

_____
City **State** **Zip** **English as a Second Language (ESL)** _____

_____/_____ **Graduate: PA___PT____FS___IPCR____MBA___Other___**
Student Cell Phone # **Birth Date**

EMERGENCY CONTACT INFORMATION

Person to be contacted in case of emergency: Name _____ Relationship _____

Home Address City State Zip Home Phone Cell Phone

HEALTH CARE PROVIDER to Complete the following required immunizations:

VACCINE	DATE	VACCINE	DATE
TDap **(within last 10 years)**	_____	**Quantiferon Gold** or **TSPOT (IGRA) test (mandatory)**	**Date:** _____ **Value:** _____ **Date:** _____ **Value:** _____
OPV (polio) Series Date, series and booster completed or titer		**Varicella Vaccine #1 (required)**	
MMR # 1 2 doses or immune titer		**Varicella Vaccine #2 (required)**	
MMR # 2 2 doses or immune titer		**Varicella Disease (Chickenpox)**	
Meningitis Vaccine (within 5 years)			

Health Care Provider Signature _____Date: _____

If Vaccine information is not completed in full with dates or titers confirming immunity; Students may obtain immunizations in SHS and will pay the following fees:

Tetanus $55.00/MMR $75.00/Meningitis $130.00/Varicella $130.00/Quantiferon God
*Fees are subject to change.

Forms must be completed in full prior to arrival to Campus

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)

☐General Wellness: _____
☐Eyes: _____
☐Skin: _____
☐Ears, Nose, Throat:_____
☐Stomach/Digestion: _____
☐Lungs/ Breathing: _____
☐Heart/Circulation:_____
☐ ☐ ☐ Muscle/Joints/Bones: _____
☐Neurological:_____
☐Allergies: _____
☐Reproductive/Urinary: _____
☐Thyroid/Endocrine: _____
☐Psychiatric: _____
☐Blood/Lymph:_____
☐Other:_____
_____

Describe any abnormalities: _____
_____
_____

	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.

_____**CRNP/MD** _____ _____

Signature Printed Name Date

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