Undergraduate 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 UNDERGRADUATE 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

***Tuberculosis Test** (Within 1 Year)

A. TB IGRA Blood Test _____ +_____ -_____

T.SPOT or QuantiGold

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

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**

IMPORTANT HEALTH INSURANCE INFORMATION

Arcadia University requires every full time student to have health insurance. Arcadia University has contracted with **United Healthcare** at a rate of $1699.00 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	☐	☐	22. Broken bones	☐	☐
2. Eye problems	☐	☐	23. Bone or joint problems	☐	☐
3. Hearing loss or ear problems	☐	☐	24. Arthritis/gout	☐	☐
4. Chronic cough	☐	☐	25. Back pain/injury	☐	☐
5. Asthma	☐	☐	26. Neck pain/injury	☐	☐
6. Shortness of breath	☐	☐	27. Loss of limb	☐	☐
7. Lung problems	☐	☐	28. Severe headaches	☐	☐
8. Tuberculosis or positive TB skin test	☐	☐	29. Dizziness or fainting	☐	☐
9. Chest pain	☐	☐	30. Epilepsy or seizures	☐	☐
10. Heart trouble/attack	☐	☐	31. Severe weakness or tiredness	☐	☐
11. Palpitations/irregular heart beat	☐	☐	32. Depression or anxiety	☐	☐
12. Heart murmur	☐	☐	33. Emotional or psychiatric problems	☐	☐
13. High blood pressure	☐	☐	34. Drug or alcohol dependency	☐	☐
14. Stroke or paralysis	☐	☐	35. Eating disorder	☐	☐
15. Stomach or intestinal problem	☐	☐	36. Bleeding or blood disorder	☐	☐
16. Liver disease/hepatitis	☐	☐	37. Immune suppression	☐	☐
17. Kidney disease	☐	☐	38. Chronic/recurrent infection	☐	☐
18. Unintentional weight change	☐	☐	39. Tumor/cancer	☐	☐
19. Thyroid problems	☐	☐	40. Anemia	☐	☐
20. Shoulder/elbow/wrist/hand pain	☐	☐	41. Diabetic	☐	☐
21. Numbness/tingling of arms or hands	☐	☐	42. Any other illness not listed	☐	☐

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)

☐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:_____
_____

	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

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.