**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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Date Placed</th>
<th>Date Read</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tuberculosis Test</strong> (Within 1 Year)**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. TB IGRA Blood Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T.SPOT or QuantiGold</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Tuberculosis PPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Placed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Read</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MMR Vaccination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. MMR Vaccination Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. MMR Vaccine #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. MMR Vaccine #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. MMR Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Measles Titer Results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Mumps Titer Results</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rubella Titer Results</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Varicella Vaccination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A. Varicella Vaccination Series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Varicella Vaccine #1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Varicella Vaccine #2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Varicella Titer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Placed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date Read</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Varicella Disease Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tdap</strong> (Within past 10 Years)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Hepatitis B Vaccination**

A. Hepatitis B 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*
Graduate Student Health Record 2019-2020

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

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.

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

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you allergic to any medications? □Yes □No</td>
<td>List all Medicines and supplements you take:</td>
</tr>
<tr>
<td>Please List: ____________________</td>
<td>Medicine or Supplement</td>
</tr>
<tr>
<td>Are you allergic to Latex? □Yes □No</td>
<td>____________________</td>
</tr>
<tr>
<td>Are you allergic to any foods? □Yes □No</td>
<td>____________________</td>
</tr>
<tr>
<td>Please List: ____________________</td>
<td>____________________</td>
</tr>
</tbody>
</table>

### 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:

1. Skin problems or chronic rash    | No Yes
2. Eye problems                   | □ □
3. Hearing loss or ear problems   | □ □
4. Chronic cough                  | □ □
5. Asthma                         | □ □
6. Shortness of breath            | □ □
7. Lung problems                  | □ □
8. Tuberculosis or positive TB skin test | □ □
9. Chest pain                     | □ □
10. Heart trouble/attack          | □ □
11. Palpitations/irregular heart beat | □ □
12. Heart murmur                  | □ □
13. High blood pressure           | □ □
14. Stroke or paralysis           | □ □
15. Stomach or intestinal problem | □ □
16. Liver disease/hepatitis       | □ □
17. Kidney disease                | □ □
18. Unintentional weight change   | □ □
19. Thyroid problems              | □ □
20. Shoulder/elbow/wrist/hand pain | □ □
21. Numbness/tingling of arms or hands | □ □
22. Broken bones                  | □ □
23. Bone or joint problems        | □ □
24. Arthritis/gout                | □ □
25. Back pain/injury              | □ □
26. Neck pain/injury              | □ □
27. Loss of limb                  | □ □
28. Severe headaches              | □ □
29. Dizziness or fainting         | □ □
30. Epilepsy or seizures          | □ □
31. Severe weakness or tiredness  | □ □
32. Depression or anxiety         | □ □
33. Emotional or psychiatric problems | □ □
34. Drug or alcohol dependency    | □ □
35. Eating disorder               | □ □
36. Bleeding or blood disorder    | □ □
37. Immune suppression            | □ □
38. Chronic/recurrent infection   | □ □
39. Tumor/cancer                 | □ □
40. Anemia                        | □ □
41. Diabetic                      | □ □
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:

<table>
<thead>
<tr>
<th>Type</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
PHYSICAL EXAMINATION
To be filled out by your Health Care Provider

Last Name                  First Name                  MI                  Date of Birth

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: ______________________________________

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                        Printed Name                     Date

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