Incoming for May 2020: ALL HEALTH REQUIREMENTS ARE DUE MAY 16TH, 2020

Masters of Public Health (MPH)
Graduate Student Health Record 2020-2021

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

***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 _____

Tuberculosis Test (If TB risk assessment is positive)

A. TB IGRA Blood Test _____ +_____ -_____
T.SPOT or QuantiGold

OR

B. Tuberculosis PPD _____ _____ +_____ -_____
Date Placed Date Read

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.

☐ **I, the student, have submitted Official Medical Records instead of/ or in conjunction with a Physicians signature.**

_____

Name of Provider (Please Print)

_____

Signature of Provider **Date**

***Immunizations required by Student Health Services in alignment with ACHA guidelines**

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Personal Medical History

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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

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PHYSICAL EXAMINATION

Must be within one year of your initial enrollment date.
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
_____
_____
_____
_____

Did you perform a Tuberculosis Risk Assessment?

If Yes, Please select from the following: ☐ Not at risk, no further action is required ☐ An IGRA or Skin Test was recommended
☐ A Chest X-Ray was recommended

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.

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Tuberculosis (TB) Risk Assessment

Last Name	First	Middle Initial	DOB

Country of Birth _____ **When did you come to the U.S.?** Month_____ Year_____

Traveled outside U.S.? ☐No ☐Yes

Have you traveled to any of the following countries?: Mexico, Guatemala, Vietnam, India, China, Haiti, or the Philippines. ☐No ☐Yes

Have you traveled to any High Risk Counties? *Refer to the list of countries through the QR CODE or website below.* ☐No ☐Yes

Website: https://www.arcadia.edu/shs/HighRiskCountries

If you have been to any of the following on the High Risk Listing, please note below

Country: When (MM/YYYY) : Duration of visit:

QR: high risk countries

HAVE YOU EVER HAD/BEEN:		
1. Previous test for TB infection **If yes, which test was done?:** ☐ Blood Test ☐ TB test **Results:** ☐ Positive ☐ Negative	☐No	☐Yes
2. Medicine for TB or for a positive skin test	☐No	☐Yes
3. Known exposure to someone with TB **If yes,** When: Relationship:	☐No	☐Yes
4. Chronic medical conditions such as diabetes, kidney problems, HIV infection, leukemia, lymphoma or any other cancers or immunosuppressant medications (Remecade, Humaria, etc.)	☐No	☐Yes
5. Worked or resided in settings such as nursing homes, homeless shelters, long-term hospital residential facilities, prisons, or have injected drugs in the past.	☐No	☐Yes

DO YOU CURRENTLY HAVE THE FOLLOWING SYMPTOMS:		
6. Productive cough lasting 3 or more weeks	☐No	☐Yes
7. Persistent weight loss without dieting	☐No	☐Yes
8. Persistent low-grade fever	☐No	☐Yes
9. Night sweats	☐No	☐Yes
10. Loss of appetite	☐No	☐Yes
12. Swollen glands, usually in the neck	☐No	☐Yes
13. Hemoptysis (Bloody Sputum)	☐No	☐Yes

IF YES to anything above, please explain by number: _____

_____

If the answer is YES to any of the above questions, Arcadia University Student Health Services requires that you receive TB testing PRIOR to the start of the semester.

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Masters of Public Health (MPH)
General Graduate Student Health Record 2020-2021

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Submitting your Records to the Patient Portal

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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**

☐ **Submit Tuberculosis Risk Assessments 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 approximately $2130.00 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 May 30th, 2020.

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

How to upload health insurance card to your Patient Portal:
Enter health insurance information via the SHS patient portal when entering your health forms. To enter your health insurance, scroll to the umbrella icon .