Student Health Services (SHS)

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

2013-2014 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 undergraduate and graduate students are required to complete this form. **Part time undergraduate and graduate students may utilize SHS with a completed health record and pay a $20.00 fee per visit.**

IDENTIFICATION

_____
Name (Last, First, Middle)

_____
Home Address (number and street)

_____
City State Zip

_____/_____
Home Telephone # Student Cell Phone #

_____
Social Security # Birth Date

REGISTRATION DATA (Circle appropriate choice)

Undergraduate: 1st year 2nd year 3rd year 4th year

Gender: Male _____ **Female** _____

Residential_____ **Commuter** _____

Graduate Program: PT PA GC IPCR FS

Full Time _____ **Part Time** _____ **Transfer**_____

EMERGENCY CONTACT INFORMATION.

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

Home Address City State Zip Home Phone Cell Phone

Work Address City State Zip Work Phone Cell Phone

IMPORTANT HEALTH INSURANCE INFORMATION

Arcadia University is a "hard waiver" institution. This requires every student to have health insurance. If the student does NOT have health insurance, he/she will be automatically enrolled in the University's student health insurance plan. The cost of the insurance premium will be billed to your account. To enroll in or waive the University student health insurance plan, please go to www.firststudent.com , select "Arcadia University" from the drop down menu, click on the "enroll now" or "waive your school's insurance" tab and follow the instructions. If there are any problems with enrollment or the waiver process, please contact the University's student health insurance broker, RCM&D at 1-800-346-4075 and speak with Lori Rupp. Ms. Rupp may also be reached via email at LRupp@RCM&D.com. Student Health Services does NOT answer questions/issues regarding "waiving out" or enrolling in health insurance.

PHYSICAL EXAMINATION

PE for: □ **Work** □ **Student Teaching** □ **Other** _____

_____ **SEX:** M □ F □
LAST NAME FIRST NAME MIDDLE

Blood Pressure _____Pulse _____ Height _____ Weight _____ lbs. BMI _____

REVIEW OF SYSTEMS: ____ Negative ____ Positive _____

_____

Are there abnormalities in the following systems? Describe fully.

ALLERGIES: _____

	No	Yes
HEENT		
Respiratory		
Cardiovascular		
Gastrointestinal		
Musculoskeletal		
Neurologic		
Skin		

Is the patient now under treatment for any medical or emotional condition? No _____ Yes _____
(Explain)

_____

Is the patient currently taking any medication on a regular basis? No _____ Yes _____
(List)

_____

****PLEASE NOTE THAT STUDENT HEALTH SERVICES (SHS) CANNOT INITATE, RENEW, OR REFILL ANY PSYCHIATRIC MEDICATIONS. STUDENTS ON PSYCHIATRIC MEDICATIONS MUST MAKE ARRANGEMENTS WITH THE PRESCRIBING PROVIDER.** ***Prescriptions can be called into Wesley Pharmacy: 108 South Easton Rd. Glenside, PA. 19038 Phone 215-887-4577 or fax 215-887-4505. Medications will be delivered to SHS free of charge for pick up. Students must call Wesley Pharmacy and give their insurance information. Students can pay for medications at SHS, using cash, credit, or student charge account.***

Is there a loss or seriously impaired function of any organ? No _____ Yes _____
(Explain)

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

Explain: _____

_____**CRNP/MD** _____ _____
Signature Printed Name Date

Student Health Services, Arcadia University
450 S. Easton Road, Glenside, PA 19038
215-572-2966 (office); 215-881-8787 (fax)

ARCADIA UNIVERSITY

REPORT OF MEDICAL HISTORY

To the Student: YOU HAVE BEEN ACCEPTED TO ARCADIA UNIVERSITY. This information is strictly for the use of Student Health Services and will not be released to anyone without your knowledge and consent.

Please complete this page before going to your health care provider for the physical examination. *Your health care provider must complete the Physical Examination and Immunization records.*

LAST NAME (Print) FIRST NAME MIDDLE INITIAL

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS – Please comment on all positive answers below (Use additional sheet if necessary**)**

Have you had?	Yes	No
Chicken Pox		
Measles		
German Measles		
Mumps		
Mononucleosis		
More than 10 lb. weight gain or loss in past year		
Females: menstrual problems		

Have you had?	Yes	No
Dental problems		
Eye problems		
Ear, nose, throat problems		
Asthma		
Seasonal Allergies		
Other medical problems (list):		

Have you had?	Yes	No
Head injury or Concussion		
Epilepsy/ seizures		
Migraines		
Anxiety or depression		
Sleep difficulty		
Eating disorder		
Alcohol/drug problem		
Learning disability		

Have you had?	Yes	No
Diseases/injury of joints		
Back problems		
Heart trouble/high blood pressure		
Stomach/intestinal problems		
Liver or kidney problems		
Skin problems		
Tumors or cysts		
Cancer		
Diabetes		

SOCIAL HISTORY (Comment below or use additional sheet if necessary)	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes, cigars or use smokeless tobacco?		
Do you take medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Explain)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Explain) Have you been hospitalized for any of the above?		
Have you had any significant illness or injury for which you have been treated or hospitalized other than already mentioned? (Explain)		
Do you have any additional information regarding your health, family history, or other matters:		

DRUG ALLERGY	Type of Reaction		Type of Reaction
☐ None		☐ Sulfa	
☐ Codeine		☐ Penicillin or Ampicillin	
☐Other Please Specify:		☐ Food allergy – please specify	

Student's Signature **Health Care Provider's Signature** Date

REMARKS OR ADDITIONAL INFORMATION (Use additional sheet if necessary):

Please note that Student Health Services (SHS) does not initiate, refill, or renew any psychiatric medications. Any psychiatric medication prescription must come from the prescribing provider. Prescriptions can be mailed into Wesley Pharmacy: 108 South Easton Rd., Glenside, PA 19038, called in at 215-887-4577 or faxed at 215-887-4505. Medications will be delivered to Student Health Services free of charge. Students must call Wesley Pharmacy and give them their health insurance information. Students can pay for prescriptions at SHS using cash, credit, debit, or student charge. Student Health Services is open weekdays only from 8:30-4:30. Please plan your prescription renewal ahead of time; remembering that SHS is closed on weekends, holidays, school breaks and in the summer. For questions/comments/clarifications please contact SHS at 215-572-2966 or SHS@arcadia.edu.

IMMUNIZATION RECORD

NAME _____ **Date of Birth:** _____

Note that the immunizations listed below are **MANDATORY.** Specify the personal, medical or religious reason for any immunization that is not given.

HEALTH CARE PROVIDER to fill out this section of required vaccines

VACCINE	DATE
DPT Series (Date series completed)	
TDAP/Adacel (Circle) (Booster in last 10 years)	
OPV (polio) Series Date, series and booster completed or titer	____ ____ ____ ____ **Fill in all 4 dates please**
MMR # 1 (if born after 1956) 2 doses or immune titer	
MMR # 2 2 doses or immune titer	
Hepatitis B # 1	
Hepatitis B # 2	
Hepatitis B # 3	
Hepatitis Titer if vaccination dates are unavailable	
Varicella Disease (date) OR	
Varivax vaccine # 1 AND	
Varivax vaccine # 2 ***per CDC guidelines: 2 vaccines required***	
Meningococcal (RESIDENTIAL STUDENTS) (A/C/Y/W-135) **or signed WAIVER**	
Tuberculosis Testing (PPD) within the last 6 months* required regardless of prior BCG inoculation) **Date:** **Result:** ☐ Neg ☐ Pos Induration _____ mm **Dates of INH therapy:** _____ - _____	If required: Chest X-Ray **Date:** _____ **Results:** ☐ Normal ☐ Abnormal _____ Provider Signature

Meningitis Vaccine Waiver
Meningitis Statement

Pennsylvania Law #955 was signed into effect July, 2002 requiring all students living in university housing to receive the meningitis vaccine or to sign a waiver of refusal. Arcadia University requires all students under age 25 and not pregnant, to receive the meningitis vaccine or sign a waiver declining the immunization. If you are out of compliance with this requirement, you will be subject to a registration restriction for the next semester and may lose University housing.

__ **DECLINE: I have read and understand the above information about meningitis and the benefits of immunization FOR RESIDENTIAL STUDENTS. I decline the meningitis vaccine at this time. I understand in declining this vaccine, I continue to be at risk for this serious disease. Incoming students may waive this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization.**

_____
Print name

_____
Signature of student **Date**

_____
Signature of Parent **Date**
(If student is 17 years of age or younger)

Healthcare Provider Information: (Physician, Nurse Practitioner, etc.)

_____ _____
Name of Provider (Please Print) Phone Number/Fax number

_____ _____
Signature of Provider: Address Date

PLEASE MAKE A COPY OF THIS ENTIRE FORM *(FOR YOUR RECORDS)* BEFORE SUBMITTING AND RETURN ORIGINAL FORM TO STUDENT HEALTH CENTER ONLY. Rev: 01/13