**Student Health Services**
**1145 King Road**
**Immaculata, PA 19345**
**610-647-4400 x3500**

**IMPORTANT**
**Completion of this form is a University requirement for registration**

# PRE-ENTRANCE REQUIREMENT:

**This form MUST be completed IN FULL and returned to the above address.**
**Deadline for completion is: July 17th**

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## PART I: To Be Completed By the Student

**(This information will become part of your confidential medial record. Please answer all questions. Consult your physician or parents if necessary.)**

1. Name ______________________ Social Security No. ______________

Address ______________________ Telephone No. ______________

City __________ State ______ Zip ______ Country ______ Date of Birth ______

2. PERSON TO NOTIFY IN CASE OF EMERGENCY:

1. Name ______________________ Relationship to Student ______________

Telephone No. Home ______________ Work ______________

3. PRIMARY PHYSICIAN/HEALTH INSURANCE:

Physician ______________________ Telephone No. ______________

Address ______________________

Health Insurance Co./HMO ______________________ Policy No.______________

HMO Address ______________________ Telephone No. ______________

**If your health insurance is an HMO, give location of nearest office site and phone number for authorization if you become sick in school.**

**CONFIDENTIALITY AND CONSENT NOTICE**

**The information contained on this health form is legally privileged and confidential and is intended only for the use of the Immaculata University Health Center. The copying or distribution of this document is prohibited. Access to clinical information is limited Health Center staff (clinical and administrative).**

**I certify that this information is true and complete to the best of my knowledge. I will notify the Student Health Center of any changes in health information. I hereby give permission to the Student Health Center to provide treatment of minor illness3es and injuries, administer prescribed medications, and seek emergency medial treatment. I agree to the release of pertinent information from my health record and in the event of a valid medical emergency or to participating affiliate agencies for clinical practicums, field work, and internships.**

**Signature of Student or Parent/Guardian if under 18** ______________________ **Date** ______________

**For Student-ATHLETES Only**

**I authorize the Immaculata Health Center to photocopy this record and forward it to the Director of Sports Medicine in the Athletic Department. I understand this will be used as my medical eligibility physical form so that I may participate in intercollegiate athletics at Immaculata University. I also give permission to the Health Center to provide the Sports Medicine staff with any and all information regarding injuries and illnesses treated by the Health Services staff.**

**Student Athlete's signature** ______________________ **Date** ______________

Name ________________________________

## PART II: Family History

| Family History | | | | | | Have any of your relatives ever had any of the following? | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Age | State of Health | Occupation | Age of Death | Cause of Death | | Yes | No | Relationship |
| Father | | | | | | Tuberculosis | | | |
| Mother | | | | | | Diabetes | | | |
| Brother | | | | | | Kidney Disease | | | |
| | | | | | | Heart Disease | | | |
| | | | | | | Arthritis | | | |
| Sisters | | | | | | Stomach Disease | | | |
| | | | | | | Asthma, Hay Fever | | | |
| | | | | | | Epilepsy, Convulsions | | | |

**PERSONAL HISTORY, PLEASE ANSWER ALL QUESTIONS. Comment on all positive answers in space below or on additional sheet.**

| HAVE YOU HAD? | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Scarlet Fever | | | Frequent Depression | | |
| Measles | | | Worry or Nervousness | | |
| German Measles | | | Recurrent Headache | | |
| Mumps | | | Recurrent Colds | | |
| Chicken Pox | | | Head Injury w/Unconsciousness | | |
| Malaria | | | Hay Fever, Asthma | | |
| Gum or Tooth Trouble | | | Tuberculosis | | |
| Sinusitis | | | Shortness of Breath | | |
| Eye Trouble | | | **Allergy** | | |
| Ear, Nose, Throat Trouble | | | Penicillin | | |
| **Surgery** | | | Sulfonamides | | |
| Appendectomy | | | Serum | | |
| Tonsillectomy | | | Foods (which) | | |
| Hernia Repair | | | Other | | |
| Other | | | Gallbladder Trouble or Gallstones | | |
| Pain/Pressure in Chest | | | Recurrent Diarrhea | | |
| Chronic Cough | | | Rupture, Hernia | | |
| Palpitations (Heart) | | | Recent Gain or Loss of Weight | | |
| High or Low Blood Pressure | | | Dizziness, Fainting | | |
| Rheumatic Fever or Heart Murmur | | | Weakness, Paralysis | | |
| Disease or Injury of Joints | | | Sexually Transmitted Disease | | |
| "Trick" Knee, Shoulder, etc. | | | Albumin/Sugar in Urine | | |
| Back Problems | | | Frequent Urination | | |
| Tumor, Cancer, Cyst | | | | | |
| Jaundice | | | **FEMALES ONLY** | | |
| Stomach or Intestinal Trouble | | | Irregular Periods | | |
| Insomnia | | | Server Cramps | | |
| Frequent Anxiety | | | Excessive Flow | | |

| Are you currently taking any prescribed medication on a regular basis or intermittent basis?<br>If yes,<br>Name of Medication___________<br>Conditions for which it is prescribed.<br>_____________________________ | **YES** | **NO** |
|---|---|---|

| Have you ever been hospitalized for an illness or injury?<br>If yes,<br>Date________________________<br>Reason for hospitalization<br>_____________________________<br>_____________________________<br>_____________________________ | **YES** | **NO** |
|---|---|---|

| Do you have any chronic health problem which requires regular treatment?<br>_____________________________<br>_____________________________<br>_____________________________<br>_____________________________ | **YES** | **NO** |
|---|---|---|

**Please give significant explanations of all above items to which you have answered YES.**

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

NAME ____________________________________________

**PART III: Required Immunization Record – To be completed by Family Physician**

**These immunizations are REQUIRED for next term registration. Failure to comply will result in a hold on next term's registration.**

| Required Immunization | Date of Vaccine or Completed Series | Date of Booster | Result if Applicable | Comments |
|---|---|---|---|---|
| MMR dose 1 | | | | |
| MMR dose 2 | | | | |
| Tetanus, Diphtheria (within 10 years) | | | | |
| Polio: please circle oral or injection | | | | |
| PPD/Tuberculosis test (within 1 year) | | | | |
| Hepatitis B | #1________________<br>#2________________<br>#3________________ | | | |
| Meningococcal/Meningitisu | | | | |

**These immunizations are STRONGLY RECOMMENDED.**

| Immunizations | Date of Vaccine or Completed Series | Date of Booster | Result if Applicable | Comments |
|---|---|---|---|---|
| Varicella/Chicken Pox | | | | |
| Influenza annually | | | | |

**If you received your Measles/Mumps/Rubella vaccine before 1971, please give the dates of each vaccine.**

**Measles:_______________________Mumps:_______________________Rubella:__________________________**

**Please attach reports of immune titer of Measles/Mumps/Rubella if available.**

**Please comment on any positive results or if any vaccination series is not complete.**

**Comments:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Medical/Religious contraindication or exemption:**

______________________________________________________________________________

**PART IV: Personal Health History – To be completed by Family Physician**

NAME ____________________________________________ DATE__________________________

Ht:__________ft __________ins. Hearing: Normal_______________ Vision : Normal_________________

Wt:______________________lbs. Abnormal_____________ Glasses_________________

Blood Pressure __________________ Explain_______________ Contacts________________

Dental Health ____________________________________________

**Are there any abnormalities of the following systems? Describe fully.**

| | NORMAL | ABNORMAL | DESCRIBE ABNORMATLITIES |
|---|---|---|---|
| **Head, Ears, Nose, Throat** | | | |
| **Eyes** | | | |
| **Respiratory** | | | |
| **Cardiovascular** | | | |
| **Gastrointestinal** | | | |
| **Hernia** | | | |
| **Genitourinary** | | | |
| **Musculoskeletal** | | | |
| **Metabolic/Endocrine** | | | |
| **Neuropsychiatric** | | | |
| **Skin** | | | |

**Allergies**

**Medication** ____________________________________________

**Food** ____________________________________________

**Other** ____________________________________________

**A. Current medications**____________________________________________

____________________________________________

____________________________________________

**B. Do you recommend the student seek services at the University Counseling Center for psychological or mental health issues? _______________YES _______________NO**

**Describe**____________________________________________

____________________________________________

**HEALTH CARE PROVIDER COMPLETING THIS FORM**

**I certify that I have examined this student and find him/her physically able to participate in intercollegiate athletics.**

**Physician's Name (please print):________________________________Date of Examination: ________**

**Signature: ____________________________________________**

**Address: ____________________________________________Telephone Number: _________**

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