



Student Health Services
 1145 King Road
 Immaculata, PA 19345
 610-647-4400 ext. 3500

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: August 1st

Part I: To Be Completed By The Student:

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

1. PERSONAL INFORMATION:

Name _____ Telephone No. _____
 Address _____
 City _____ State _____ Zip _____ Country _____
 Social Security No. _____ Date of Birth _____

2. PERSON TO NOTIFY IN CASE OF EMERGENCY:

Name _____ Relation to Student _____
 Home _____ Work _____ Cell _____

3. PRIMARY PHYSICIAN/HEALTH INSURANCE:

Physician _____ Telephone No. _____
 Address _____
 Health Insurance Co./HMO _____ Policy No. _____
 Address _____ Telephone No. _____

(If your health insurance is an HMO, give location of the nearest office 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 distributing of this document is prohibited. Access to clinical information is limited to 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 illnesses and injuries, administer prescribed medications, and seek emergency medical treatment. I agree to the release of pertinent information from my health record in the event of a valid medical emergency or to participating affiliate agencies for clinical practicum, field work, and internships.

Signature of Student or Parent/Guardian if under 18 _____ Date _____

FOR STUDENT ATHLETES ONLY

I authorize the Immaculata University 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 Sports Medicine staff with any and all information regarding injuries and illnesses treated by the Health Services staff.

Signature of Student or Parent/Guardian if under 18 _____ 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			
Brothers						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 the space below.

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

Please give significant explanation of all above items to which you answered yes.

Are you currently taking any prescribed medication on a regular or intermittent basis? Yes _____ No _____
 If yes, name of medication and condition for which it is prescribed.

Have you ever been hospitalized for an illness or injury? Yes _____ No _____
 If yes, date and reason for hospitalization.

Do you have any chronic health problems which require regular treatment? Yes _____ No _____

Name: _____

Part III: Required Immunization Record – To Be Completed by Family Physician

These immunizations are REQUIRED to obtain campus housing and term registration. Failure to comply will result in a hold of registration and/or campus housing.

Required Immunizations	Date of Vaccine or Completed Series	Date of Booster	Result of 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				
Meningococcal/Meningitis				

The following immunizations are STRONGLY RECOMMENDED.

Required Immunizations	Date of Vaccine or Completed Series	Date of Booster	Result of 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 comments on any positive results or if any vaccination series is not complete.

Comments: _____

Medical/Religious contraindications or exemption: _____

Part IV: Personal Health History – To Be Completed by Family Physician

NAME _____ DATE _____

Height: _____ ft. _____ ins. Weight: _____ lbs.

Hearing: Normal _____ Abnormal _____ Explain: _____

Vision: Normal _____ Abnormal _____ Explain: _____

Dental Health: _____

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

	Normal	Abnormal	Describe Abnormalities
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Allergies

Medication: _____

Food: _____

Other: _____

1. Current Medications: _____

2. 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 Signature: _____ Date: _____

Name: _____ Telephone No. _____

Address: _____
