Name: _____

Cell : (Student)_____

Marywood

UNIVERSITY

STUDENT HEALTH SERVICES

Health History
Physical Examination
Immunization Record

THIS FORM IS MANDATORY AND DUE BY AUGUST 1

Please return completed form to:
Marywood University Health Services
2300 Adams Avenue • Scranton, PA 18509

Lead On.

Marywood University Health Services
Scranton, PA 18509
(570) 348-6249 • Fax (570) 961-4735

HEALTH HISTORY

You have been accepted to Marywood University. This information is CONFIDENTIAL and is to be used strictly by the Health Services as an aid in providing health care. No information will be released without your knowledge and written consent.
PLEASE COMPLETE THIS PORTION BEFORE GOING TO YOUR HEALTH PROVIDER.

Last Name _____ First _____ Middle _____ Date of Birth _____ I.D. Number _____

Home Address _____ City/Town _____ State _____ Zip Code _____ Phone Number _____

Next of Kin to be Contacted in Emergency _____ Relationship _____ Phone Number _____

Business Address _____ Business Phone Number _____

Sex: _____ Marital Status:_____ Major:_____ ❑ Resident Student ❑ Commuter Student

Health Insurance Policy:
Company _____
Policy # _____
Name of Insured: _____

FAMILY HISTORY

	Age	Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Medication Allergies: ❑ **Yes** ❑ **No** **Please List and Note Reaction:**_____
Latex Allergy: ❑ **Yes** ❑ **No**
Are you currently taking any prescribed medications? Yes _____ No _____ List with Dosage _____

Personal Medical History. Have you ever had…? Check yes if applicable.

HAVE YOU HAD?	YES		YES		YES
Asthma		Fainting		Mumps	
Bleeding Tendency		German Measles		Rheumatic Fever	
Chicken Pox		Headaches (Migraine)		Scarlet Fever	
Colitis		Heart Disease -		Sexually Transmitted Disease	
Concussions		Mitral Valve prolapse		Strep History	
Depression		Murmur		Substance Abuse -Alcohol/Drugs	
Dental Problems		Hepatitis		Surgery list:	
Diabetes		HIV		Tuberculosis	
Eating Disorder		Hypoglycemia		Tumor - Cancer	
Anorexia		Infectious Disease		Ulcers	
Bulimia		Kidney Disease		Urinary Tract Infection	
Epilepsy/History of Seizures		Measles			

***OPTIONAL:** Do you require accommodation to a disability? If so, please give specifics on the accommodations required in the space below or attach letter of explanation. We would like to share information with the appropriate offices on campus. Please check this box if we have your authorization to do so. ❑

Authorization for Treatment: I hereby authorize the Marywood health provider to treat _____ for any illness or accident deemed necessary by the university health provider. I understand that in case of serious medical emergency, every effort will be made to contact me. I will be responsible for all bills incurred.

Signature of Student _____ Date _____ Signature of Parent or Guardian _____ Date _____

I authorize release of relevant medical information or records to my parents/guardian. ❑ Yes ❑ No

Signature of Student _____ Date _____

PHYSICAL EXAMINATION

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****

Last Name	First	Middle	Sex
Blood Pressure ____/____	Pulse ____/____	Height _____	Weight _____
Visual Acuity	(R) 20 / _____	(L) 20 / _____	

SYSTEMS REVIEW

	Normal	Abnormal	Describe Abnormalities
Skin	_____	_____	_____
HEENT	_____	_____	_____
Lymph Nodes	_____	_____	_____
Neck	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Respiratory	_____	_____	_____
Gastrointestinal	_____	_____	_____
Genitourinary	_____	_____	_____
Reproductive	_____	_____	_____
Endocrine	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neuro/Psych	_____	_____	_____

GENERAL COMMENTS:

Is there any loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals)

Unlimited _____ Limited _____ Explain: _____

_____

Do you have any recommendations regarding the care of this patient? _____

_____

Is this patient now under treatment for any medical or emotional condition?_____

_____

This patient is free of communicable disease Yes ❑ No ❑

HEALTH PROVIDER'S SIGNATURE _____**MD ❑ DO ❑ PA-C ❑ NP ❑**

DATE OF PHYSICAL EXAM _____

Health Provider's Name (please print) _____

Address: _____

Telephone Number: (_____) - _____ Fax: (_____) - _____

IMMUNIZATION RECORD

*****This section is to be completed and signed by an MD, DO, PA-C, or a NP*****
Day, month and year must be completed.

_____
Last Name First Middle

IMMUNIZATIONS MUST BE UPDATED AS SPECIFIED BELOW.

A. TETANUS-DIPHTHERIA

1. ❑ Completed primary series of tetanus-diphtheria immunizations . . . . . _____/_____/_____
2. ❑ Received diphtheria, pertussis, tetanus booster within the last 10 years . . . . . Td:_____/_____/_____
   Tdap:_____/_____/_____

B. M.M.R. (Measles, Mumps, Rubella)

1. ❑ Dose 1 - Immunized at 12 months . . . . . _____/_____/_____
2. ❑ Dose 2 - Immunized at 4-6 years and at least one month after first dose . . . . . _____/_____/_____

C. Hepatitis B Vaccine (three doses or a positive Hepatitis B surface antibody titer meets the requirement).

❑ Dose 1 . . . . . _____/_____/_____
❑ Dose 2 . . . . . _____/_____/_____
❑ Dose 3 . . . . . _____/_____/_____

D. Varicella

❑ History of disease . . . . . _____/_____/_____
❑ Vaccine Dates: Dose 1 ..... _____/_____/_____ Dose 2 . . . . . _____/_____/_____

E. Tuberculosis Screening (PPD regardless of prior BCG inoculation). A two step, within a 3-week interval, is required for all Nursing, Nutrition/Dietetic, and Physician Assistant Students in **sophomore year**.

1. PPD (Mantoux) Test within the past year (**Tine or monovac not acceptable**).
   PPD #1 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
   PPD #2 Date Given: _____/_____/_____ Result: : ❑ Positive ❑ Negative
2. **Positive PPD – Chest x-ray required. Must submit a copy of the chest x-ray reading.**

F. Polio

❑ Completed primary series of polio immunizations: _____Yes _____ No
❑ Type of vaccine: _____ Oral _____ Inactive _____ E-IPV
❑ Last Booster . . . . . _____/_____/_____

G. Meningitis – Pennsylvania law mandates that ALL students living in university owned housing be immunized or sign a waiver after receiving information on the disease and vaccine.

❑ Vaccine1 _____/_____/_____ ❑ Vaccine 2 _____/_____/_____

H. Influenza . . . . . _____/_____/_____

HEALTH CARE PROVIDER

Name: _____ Address: _____

Signature: _____ **MD ❑ DO ❑ PA-C ❑ NP ❑** Phone: ( ) _____