NAME: _____ DATE OF BIRTH: ____ / ____ / ____

SJU Saint Joseph's University

DUE JULY 1, 2017

HEALTH EVALUATION
STUDENT HEALTH CENTER

INCOMING STUDENT: This form is to be completed prior to your arrival on campus. It requires a brief health history, insurance documentation, a physical examination and a record of your immunizations. To assure that your records are received and reviewed prior to your arrival, **please return your completed form no later then July 1** to **Saint Joseph's University, Student Health Center, Sourin Hall, 5600 City Avenue, Philadelphia, PA 19131**. If you have any questions please call (610) 660-1175. This information is strictly for the use of the Health Center and will not be released to anyone without your knowledge and consent.

PLEASE RETAIN A COPY OF THIS FORM BEFORE SUBMITTING.

FAILURE TO COMPLY WILL RESULT IN A MEDICAL HOLD, PREVENTING REGISTRATION.

_____ GENDER _____

LAST NAME (print) FIRST NAME MIDDLE

_____ _____ 10 ____ ____ ____ ____ ____ ____ ____

(date of birth) STUDENT'S CELL PHONE SJU ID#

CHECK ALL THAT APPLY: ❑ Undergraduate ❑ Graduate ❑ Campus Housing ❑ Commuter ❑ International ❑ Transfer

_____

HOME ADDRESS (number and street) CITY OR TOWN STATE ZIP CODE HOME TELEPHONE

_____

EMERGENCY CONTACT NAME (relationship) PHONE

ACCIDENT AND/OR HEALTH INSURANCE

(Attach copy of card front and back)

Primary Insurance Company Name _____

Member / ID # _____ Group # _____

Insurance Address _____

City _____ State _____ Zip Code _____

Member/Customer Service Phone Number _____

Students Relationship to insured ❒ Self ❒ Spouse ❒ Dependent

Name of Policy Holder _____ Policy Holders Date of Birth_____

Policy Holder's Signature _____ Referral required? _____

If laboratory testing is needed, please indicate which lab your insurance requires Quest _____ Lab Corp_____

Saint Joseph's University requires all full-time undergraduates and all international students to show proof of health insurance coverage. STUDENTS ARE REQUIRED TO COMPLETE AN ON-LINE WAIVER OR ENROLLMENT FORM. For more information visit www.firststudent.com.

CONSENT FOR TREATMENT ***(required for students under 18):***

I hereby give consent for my minor child, _____ to receive routine care through the SJU Health Center and in the event of an EMERGENCY, give permission to the Health Center and its affiliated hospital to secure for this child appropriate treatment.

CONSENT FOR TREATMENT ***(students over 18):***

In the event of an EMERGENCY, I hereby give permission to the SJU Health Center and its affiliated hospital to secure for me appropriate treatment.

_____

Signature of Parent or Guardian Print Name of Parent or Guardian Signature of Student ***(over age 18)***

NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers					
Sisters					

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

MEDICAL HISTORY (To be completed by student)

PLEASE CHECK BELOW IF YOU HAVE HAD OR ARE CURRENTLY UNDER TREATMENT FOR ANY OF THE FOLLOWING. (Please explain all checkmarks in section below)

- ❑ Allergies (please specify)
  - ❑ Medications _____
  - ❑ Food _____
- ❑ German Measles (Rubella)
- ❑ Measles
- ❑ Mumps
- ❑ Infectious Mononucleosis
- ❑ Scarlet Fever
- ❑ Anemia
- ❑ Thyroid Disorder
- ❑ Diabetes Mellitus
- ❑ Cancer
- ❑ Asthma
- ❑ Exercise-induced Asthma
- ❑ Shortness of Breath with Exercise
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Recurrent Bronchitis
- ❑ Recurrent Ear Infection
- ❑ Cardiac:
  - ❑ *Marfan's Syndrome*
  - ❑ *Congenital Condition*
  - ❑ *Murmur*
  - ❑ *Rheumatic Heart Disease*
  - ❑ *High Blood Pressure*
  - ❑ *Heart Palpitations*
  - ❑ *Chest Pain or Pressure*
  - ❑ *High Cholesterol*
  - ❑ *Other: Specify* _____
- ❑ Disability:
  - ❑ *Vision*
  - ❑ *Hearing*
  - ❑ *Locomotion*
  - ❑ *Other Motion*
  - ❑ *Learning*
  - ❑ *Emotional*
  - ❑ *Other, explain* _____

  _____
- ❑ Emotional Disorder:
  - ❑ *Eating Disorder*
  - ❑ *Drug/Alcohol Dependency/Abuse*
  - ❑ *Depression*
  - ❑ *Panic/Anxiety Disorder*
  - ❑ *Bipolar Disorder*
  - ❑ *Mood Disorder*
  - ❑ *Obsessive Compulsive Disorder*
  - ❑ *Thoughts of hurting oneself*
  - ❑ *Hospitalized for Emotional Disorder*
  - ❑ *Other, explain* _____
- ❑ Trouble sleeping
- ❑ Bone Fractures
- ❑ Joint Injury
- ❑ Arthritis
- ❑ Scoliosis
- ❑ Back Pain/Problems
- ❑ Osgood-Schlatter
- ❑ Other Musculoskeletal Disorders
- ❑ Neurological Disorders
- ❑ Head Injury with loss of Consciousness
- ❑ Concussion
- ❑ Fainting/Dizziness
- ❑ Seizure Disorder
- ❑ Recurrent Sinusitis
- ❑ Recurrent Nosebleeds
- ❑ Vision Problems
- ❑ Hearing Loss
- ❑ Speech Defects
- ❑ Migraine Headaches
- ❑ Syncope or Fainting with Exercise
- ❑ Tension Headaches
- ❑ Ulcer
- ❑ Inflammatory Bowel Syndrome
- ❑ Irritable Bowel Syndrome
- ❑ Hepatitis
- ❑ Pancreatitis
- ❑ Gall Bladder Problems
- ❑ Reflux
- ❑ Rectal Bleeding
- ❑ Hernia
- ❑ Recurrent Bladder Infection
- ❑ Blood in Urine
- ❑ Kidney Infection
- ❑ Chronic Kidney Disease
- ❑ Sexually Transmitted Disease
- ❑ Pelvic/Vaginal Infections
- ❑ Testicular Lump
- ❑ Testicular Torsion
- ❑ Menstrual History
  - ❑ *painful periods*
  - ❑ *heavy flow*
  - ❑ *irregular periods*
  - ❑ *Age of 1st period* _____
- ❑ Pregnancy
- ❑ Eczema
- ❑ Hives
- ❑ Acne
- ❑ Chronic rash
- ❑ Heat Related Illness
- ❑ Serious Accident/Injury
- ❑ Surgeries
  - ❑ *Tonsillectomy*
  - ❑ *Adenoidectomy*
  - ❑ *Other, explain* _____

  _____

Do you use tobacco?
❑ Yes ❑ No ___ pks./day

Do you drink alcohol
❑ Yes ❑ No ___ amt./week

Explanation for any positive answers: _____
_____
_____
_____
_____
_____

NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____

PHYSICAL EXAMINATION (within one year)

To be completed by a healthcare provider: Please review the student's history and complete this form. Please comment on all positive answers. The information supplied will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of the Student Health Center and will not be released without student consent.

BP / HEIGHT _____ inches WEIGHT _____ lbs VISUAL ACUITY: Right 20 / _____ Left 20 / _____

Medication Allergies: _____

Current Medications: _____

_____

_____

_____

CLINICAL EVALUATION

	NORMAL	ABNORMAL	COMMENTS
1. Skin			
2. Head, Ears, Eyes, Nose, Throat			
3. Mouth, Teeth, Gums			
4. Neck and Thyroid			
5. Lungs/Chest			
6. Breasts			
7. Heart			
8. Abdomen			
9. Genitalia			
10. Back/Spine			
11. Extremities/Musculoskeletal			
12. Neurologic			
13. Emotional/Psychological			
14. Other Findings			

Recommendation for physical activities, including participation in club, intramural & intercollegiate sports:

❑ Unlimited ❑ Limited If Limited, please explain: _____

_____

This student is able to meet the physical and emotional demands of college life:

❑ Yes ❑ No If No, please explain: _____

_____

_____

Signature of Healthcare Provider Healthcare Provider Stamp Date

_____

Print name of Healthcare Provider Address Telephone Fax

NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____

IMMUNIZATION RECORD

– NO ATTACHMENTS PLEASE –

Request for medical/religious exemption: Complete Request for Exemption Form

REQUIRED IMMUNIZATIONS

1. MMR *(measles, mumps, and rubella)*:
Immunization with two doses of MMR, given on or after first birthday and separated by at least one month.
Date 1: ___/___/___
Date 2: ___/___/___

2. TETANUS/DIPHTHERIA/PERTUSSIS:
Three doses of tetanus/diphtheria/pertussis are required with a booster given within the past ten years.
Date 1: ___/___/___
Date 2: ___/___/___
Date 3: ___/___/___
Tdap Booster: ___/___/___

3. POLIO:
Three doses; Booster only if needed for travel.
Date 1: ___/___/___
Date 2: ___/___/___
Date 3: ___/___/___

4. VARICELLA VACCINE *(Chicken Pox)*:
Two properly spaced doses of varicella vaccine, laboratory evidence of immunity or reliable history of varicella.
Hx of Disease: _____ ❑ Yes ❑ No
Date 1: ___/___/___
Date 2: ___/___/___

5. TUBERCULOSIS TESTING/PPD (within the past year) **-**
Recommended for all students; only REQUIRED for:
- Education Majors
- Anyone who has lived in or visited South America, Central America, Eastern Europe, Asia or Africa in the last 5 years
- Students in contact with a known case

TUBERCULOSIS TESTING (PPD)	**If required: chest x-ray results:**
Date: _____	❑ Normal
Result: ❑ Neg ❑ Pos	❑ Abnormal
Induration _____mm	(M/D/Y) _____

A chest x-ray is required if the student has had tuberculosis, has a positive reaction or has a past known positive PPD.
If the student has had a positive tuberculin test, did he/she receive prophylactic medication? ❑ Yes ❑ No

6. MENINGOCOCCAL QUADRIVALENT VACCINE (A, C, Y, W-135): _____ Menomune _____ Menactra _____ Menveo
PA State Law requires students living in campus housing to have documentation of a dose of conjugated vaccine.
Vaccination is recommended at 11-12 years of age with a booster at/after age 16.
Click here to learn more about meningococcal vaccine.
Date 1: ___/___/___
Date 2: ___/___/___

MENINGITIS WAIVER

❑ **DECLINE:** I have read the enclosed information about Meningococcal Meningitis vaccine; however, I decline the vaccine at this time. I understand that in declining this vaccine, I continue to be at risk for this serious disease. I further understand, that if I change my mind in the future and want the vaccine, I can receive it at the Student Health Center. ***If student under the age of 18, parental consent is necessary.***

_____	_____	_____	_____
Student Signature	Date	Parent Signature (if student is under age 18)	Date

RECOMMENDED IMMUNIZATIONS

HEPATITIS B:
Series of 3 doses; 0, 1, 6 months
Date 1: ___/___/___
Date 2: ___/___/___
Date 3: ___/___/___

HEPATITIS A:
Series of 2 doses; 0, 6 months
Date 1: ___/___/___
Date 2: ___/___/___

MENINGOCOCCAL B VACCINE:
Bexsero Date 1: ___/___/___
Date 2: ___/___/___
Trumenba Date 1: ___/___/___
Date 2: ___/___/___
Date 3: ___/___/___