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 than 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.**

## DUE DECEMBER 1

**SAINT JOSEPH’S UNIVERSITY**

**HEALTH EVALUATION**

**STUDENT HEALTH CENTER**

**LAST NAME** (print) **FIRST NAME** **MIDDLE**

(general information)

<table>
<thead>
<tr>
<th>LAST NAME (print)</th>
<th>FIRST NAME</th>
<th>MIDDLE</th>
<th>GENDER</th>
<th>PREFERRED NAME</th>
<th>PREFERRED PRONOUNS</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

**DATE OF BIRTH:**

(due date)

**STUDENT’S CELL PHONE**

(phone number)

**SJU ID#**

(id number)

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**

(health insurance)

<table>
<thead>
<tr>
<th>Member / ID #</th>
<th>Group #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Insurance Address**

(city, state, zip)

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Member/Customer Service Phone Number**

(phone number)

**Students Relationship to insured**

- Self
- Spouse
- Dependent

**Name of Policy Holder**

(policy holder name)

<table>
<thead>
<tr>
<th>Policy Holders Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Policy Holder’s Signature**

(signature)

**Referral required?**

(referral)

If laboratory testing is needed, please indicate which lab your insurance requires

<table>
<thead>
<tr>
<th>Quest</th>
<th>Lab Corp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**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](http://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**

(signature)

**PRINT NAME OF PARENT OR GUARDIAN**

(print name)

**SIGNATURE OF STUDENT***(over age 18)

(signature)

**SIGNATURE OF STUDENT***(over age 18)

(signature)

[www.sju.edu/studenthealth](http://www.sju.edu/studenthealth)
FAMILY HISTORY

<table>
<thead>
<tr>
<th>AGE</th>
<th>STATE OF HEALTH</th>
<th>OCCUPATION</th>
<th>AGE OF DEATH</th>
<th>CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

<table>
<thead>
<tr>
<th>RELATIONSHIP</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, Hay Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy, Convulsions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NAME: _______________________________________________________________ DATE OF BIRTH: _____ / _____ / _____

M ED I C A L H I S T O R Y (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)
  - 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
    - Autism Spectrum
    - 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
- RecurrentSinusitis
- 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: __________________________________________

_________________________________________

_________________________________________

_________________________________________

_________________________________________

www.sju.edu/studenthealth
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

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

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

www.sju.edu/studenthealth
IMMUNIZATION RECORD
– TO BE COMPLETED BY HEALTHCARE PROVIDER –

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

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

Date 1: __/___/___
Date 2: __/___/___

Menomune  Menactra  Menevo
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.

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                                          Parent Signature (if student is under age 18)
__________________________________          ___________________________
          Date                         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: __/___/___  Trumenba  Date 1: __/___/___
          Date 2: __/___/___          Date 2: __/___/___
          Date 3: __/___/___          Date 3: __/___/___