

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



**DUE JULY 1**  
**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 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.**

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

LAST NAME (print) \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE \_\_\_\_\_ GENDER \_\_\_\_\_

\_\_\_\_\_ 10 \_\_\_\_\_  
(date of birth) STUDENT'S CELL PHONE SJU ID# PREFERRED PRONOUNS

PREFERRED NAME \_\_\_\_\_

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](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

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
  - 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
- 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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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### 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

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## IMMUNIZATION RECORD

- TO BE COMPLETED BY 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

**TUBERCULOSIS TESTING (PPD)**

Date: \_\_\_\_\_

Result:  Neg  Pos

Induration \_\_\_\_\_ mm

**If required: chest x-ray results:**

Normal

Abnormal

(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: \_\_\_\_/\_\_\_\_/\_\_\_\_