Ursinus College

Confidential Health Record

****FOR STUDENT TO COMPLETE****

LEGAL NAME_____ **D.O.B.**_____ **CELL #** _____

PREFERRED NAME_____**PREFERRED PRONOUNS**_____**SEX** _____ **GENDER IDENTITY** _____

PERMANENT HOME ADDRESS_____
(Street) (City) (State) (Zip)

IN CASE OF EMERGENCY NOTIFY_____
(Name) (Phone) (Relationship)

FAMILY PHYSICIAN_____
(Name) (Address) (Phone)

ALLERGIES/SENSITIVITIES (include reaction):

01 ☐ Macrolides_____
02 ☐ Penicillin_____
03 ☐ Sulfa_____
04 ☐ Pollen_____
05 ☐ Insect _____
06 ☐ Animal_____
07 ☐ Food_____
08 ☐ **None known** _____
09 ☐ Other (please specify)
_____

PRESENT MEDICATIONS (include dosage):

_____
_____
_____

PLEASE CHECK ANY OF THE FOLLOWING IF THEY APPLY:

HEART CONDITION

01 ☐ Congenital
02 ☐ Murmur, uncertain cause
03 ☐ Mitral Valve Prolapse
04 ☐ Rheumatic Heart Disease
05 ☐ Valvular Heart Disease
06 ☐ Other (please specify)
_____

DO YOU NOW HAVE OR ARE YOU UNDER TREATMENT FOR ANY OF THE FOLLOWING PROBLEMS? PROBLEMS?

01 ☐ Acne (under treatment)
02 ☐ Acquired Immune Deficiency Syndrome
03 ☐ ADD/ ADHD
04 ☐ Ankylosing Spondylitis
05 ☐ Anxiety
06 ☐ Binge Eating
07 ☐ Bipolar/Mood disorder
08 ☐ Blood Disorders
09 ☐ Cerebral Palsy
10 ☐ Chronic Bronchitis
11 ☐ Chronic kidney condition
12 ☐ Chronic inflammatory bowel disease
13 ☐ Condyloma (genital warts)
14 ☐ Depression
15 ☐ Diabetes Mellitus
16 ☐ Digestive troubles
17 ☐ Dizziness/fainting
18 ☐ Dysmenorrhea (severe menstrual cramps)
19 ☐ Hayfever
20 ☐ High Blood Pressure
21 ☐ Insomnia
22 ☐ Migraine
23 ☐ Multiple Sclerosis
24 ☐ Muscular Dystrophy
25 ☐ Obesity
26 ☐ Psoriasis
27 ☐ Recurrent diarrhea
28 ☐ Reiter's Syndrome
29 ☐ Recurrent headaches
30 ☐ Rheumatoid Arthritis
31 ☐ Systemic Lupus Erythematosus
32 ☐ Tuberculosis or ⊕ TB test
33 ☐ Laxative use for weight loss
34 ☐ Vomiting for weight loss
35 ☐ **None of the above**
36 ☐ Other (please specify)
_____
_____
_____

FAMILY MEDICAL HISTORY

01 ☐ Alcoholism
02 ☐ Anemia
03 ☐ Bleeding tendency
04 ☐ Cancer
05 ☐ Diabetes
06 ☐ Heart disease
07 ☐ Hereditary disease
08 ☐ High Blood Pressure
09 ☐ Mental Illness
10 ☐ Migraine
11 ☐ Obesity
12 ☐ Sudden death
13 ☐ Stroke
14 ☐ Tuberculosis
15 ☐ **None known**
16 ☐ Other (please specify)
_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

01 ☐ Anxiety
02 ☐ Anemia
03 ☐ Anorexia Nervosa
04 ☐ Asthma
05 ☐ Frequent UTI
06 ☐ Bleeding tendency
07 ☐ Bulimia
08 ☐ Cancer or malignancy
09 ☐ Chicken Pox
10 ☐ Irritable Bowel Syndrome
11 ☐ Crohn's disease
12 ☐ Diabetes
13 ☐ Depression
14 ☐ Drug, Alcohol Abuse/Addiction
15 ☐ Head Injury/Concussion
16 ☐ Hypertension
17 ☐ Infectious Mononucleosis (Mono)
18 ☐ Kidney stones
19 ☐ Major Joint Injury
20 ☐ Menstrual Disorders
21 ☐ Obesity
22 ☐ Passing out
23 ☐ Pelvic Infection
24 ☐ Peptic ulcer
25 ☐ Phlebitis
26 ☐ Rheumatoid Arthritis
27 ☐ Seizure Disorders
28 ☐ Self Harm
29 ☐ Suicide Ideation
30 ☐ Thyroid Disease
31 ☐ Tuberculosis or ⊕ TB test
32 ☐ Ulcerative Colitis
33 ☐ Sexually Transmitted Diseases
34 ☐ Hepatitis
35 ☐ **None of the above**
36 ☐ Other (please specify)
_____
37 ☐ Please explain check marks
_____

LIST CONSULTANTS AND SPECIALISTS SEEN RECENTLY OR ON A REGULAR BASIS: _____
_____
_____

PLEASE LIST ANY SPECIAL NEEDS (DIET, TREATMENTS, ETC): _____
_____
_____

REPORT OF MEDICAL EXAMINATION

****FOR PHYSICIAN TO COMPLETE****

TO THE EXAMINING PHYSICIAN: This student has been accepted. Please review the student's history and complete this examination with comments on any diseases or defects. **PLEASE BE AS THOROUGH AS POSSIBLE**

Blood Pressure _____ _____ Pulse_____ Height _____ Weight_____ BMI_____

DISTANT VISION *(do both if correction required)*

Uncorrected Right 20/_____ Corrected to 20/_____
Uncorrected Left 20/_____ Corrected to 20/_____

Does the individual wear Corrective lenses? ❑ Glasses ❑ Contacts

GROSS HEARING_____

CLINICAL EVALUATION

	Normal	Abnormal	Not Examined	Describe details of abnormalities of number
1. Head and Scalp				
2. Nose and Throat				
3. Mouth and Dentition				
4. Ears				
5. Eyes				
6. Lungs and Chest				
7. Heart				
8. Vascular system				
9. Abdomen				
10. Genitourinary				
11. Endocrine, Metabolic System				
12. Musculoskeletal System				
13. Skin				
14. Neurological System				
15. Psychiatric				

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1. Is there known loss or seriously impaired function of ANY ORGAN? ❑ Yes ❑ No

2. Should this individual **be restricted** from participating in: Physical education activity classes? ❑ Yes ❑ No

Intramural/Athletic club activity? ❑ Yes ❑ No

Intercollegiate sports? ❑ Yes ❑ No

*If physical education activities must be restricted please specify the type of activities and specific limitations.
(Please attach your details on your letterhead about activities.)

3. General comments or recommendations:_____

4. Is this individual currently under care for a chronic condition or serious illness? ❑ Yes ❑ No If yes, please list: _____

5. Will this individual be taking medication on a regular basis? ❑ Yes ❑ No If yes, please list: _____

6. Please confirm psychiatric status with diagnoses and medications if applicable:_____

PHYSICIAN'S SIGNATURE_____ **DATE**_____

Print Name_____ Telephone Number _____

Address_____

IMMUNIZATION RECORD

Name_____D.O.B._____

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. ***ALL INFORMATION MUST BE IN ENGLISH.***

THE FOLLOWING ARE MANDATORY FOR ADMISSION:

IF YOU ARE ATTACHING RECORDS PLEASE MAKE SURE THEY FIT THE REQUIREMENTS BELOW!

A. TETANUS-DIPHTHERIA-PERTUSSIS (DTaP/TdaP) OR TETANUS-DIPHTHERIA (DT) (CIRCLE ONE)
Within the last 10 years ……..……..…… _____/_____ (Mo / Yr)

B. M.M.R. (MEASLES, MUMPS, RUBELLA) (two doses required)
1. Dose 1 given at age 12-15 months or later…..…… #1_____/_____ (Mo / Yr)
2. Dose 2 given at age 4-6 years or later, and at least one month after first dose.……..…#2_____ /_____ (Mo / Yr)

C. POLIO
1. Completed primary series of polio immunization: Yes_____ No_____ Date of last booster:……..... _____ /_____ (Mo / Yr)

D. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement)
1. History of disease Yes_____ No_____
2. Varicella antibody _____/_____ (Mo / Yr) Reactive_____ Non-reactive_____
3. Immunization
   a. Dose #1……..……#1_____/_____ (Mo / Yr)
   b. Dose #2 given at least one month after first dose, if age 13 years or older……#2_____/_____ (Mo / Yr)

E. TUBERCULOSIS SCREENING (PLEASE DO NOT SKIP SCREENING QUESTIONS!)
1. Does the student have signs or symptoms of active tuberculosis disease? Yes_____ No_____
   If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions? Yes_____ No_____
   If No, STOP. If Yes, place tuberculin skin test (Mantoux only; Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally onto the surface of the forearm OR do blood test (see #5).
   A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test:

   Date Given:_____/_____/_____ (Mo / Day / Yr) Date Read:_____/_____/_____ (Mo / Day / Yr)

   Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")
   Interpretation (based on mm of induration as well as risk factors): Positive_____ Negative_____
4. Chest x-ray (required if tuberculin skin test is positive) result: Normal_____ Abnormal_____

   Date of chest x-ray:_____/_____/_____ (Mo / Day / Yr)
5. QuantiFERON Gold blood test results: _____

F. HEPATITIS B (at least one of the following):
1. Immunization (Hepatitis B)
   a. Dose #1 _____/_____ (Mo / Yr) **b.** Dose #2 _____/_____ (Mo / Yr) **c.** Dose #3 _____/_____ (Mo / Yr)
2. Immunization (combined Hepatitis A and B Vaccine)
   a. Dose #1 _____/_____ (Mo / Yr) **b.** Dose #2 _____/_____ (Mo / Yr) **c.** Dose #3 _____/_____ (Mo / Yr)
3. Hepatitis B surface antibody Date_____/_____ (Mo / Yr) Result: Reactive _____ Non-reactive_____

G. MENINGOCOCCAL MENINGITIS (GROUP A) (Must have one dose AFTER age 16)
1. Date _____/_____ **2.** Date _____/_____
Mo Yr Mo Yr

H. FOR STUDENT ATHLETES ONLY: SICKLE CELL SCREENING
Date_____/_____ Result:_____
Mo Yr

THE FOLLOWING ARE OPTIONAL BUT HIGHLY RECOMMENDED

I. HEPATITIS A
1. Immunization (Hepatitis A)
a. Dose #1 _____/_____ **b.** Dose #2 _____/_____
Mo Yr Mo Yr

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE (for members of high-risk group)
Prevnar 13® Date_____/_____ Pneumovax® Date_____/_____
Mo Yr Mo Yr

K. INFLUENZA* (Annual immunization recommended for **everyone**)
Date_____/_____
Mo Yr

***THIS VACCINE WILL BE OFFERED DURING THE FALL AT A NOMINAL FEE**

L. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV):
(Three doses of vaccine recommended for all college students 11-26 years of age at 0, 2, and 6 month intervals.)
a. Dose #1 _____/_____ **b.** Dose #2 _____/_____ **c.** Dose #3 _____/_____
Mo Yr Mo Yr Mo Yr

M. MENINGOCOCCAL (GROUP B)
Bexsero®: Date ____/_____ Date____/_____ **OR** Trumenba®: Date ____/_____ Date_____/_____ Date_____/_____
Mo Yr Mo Yr Mo Yr Mo Yr Mo Yr

Health Care Provider

Signature _____

Name _____ **Phone** _____ **Fax:** _____

Address _____

_____

_____

E-mail: _____

If there are any questions or concerns, please contact Paul P. Doghramji, MD, UC Medical Director, or the Wellness Center Office Manager at wellness@ursinus.edu.

RETURN TO: Ursinus College Wellness Center
NO LATER THAN: July 30th for Fall Registration & January 30th for Spring Registration

URSINUS COLLEGE WELLNESS CENTER
601 E. Main St. Collegeville, PA 19426
PH: 610-409-3100 FAX: 610-409-3778