University Wellness Center
Carter Hall
250 University Avenue
California, Pennsylvania 15419-1394
Phone: (724) 938-4232 FAX:(724) 938-4509

MEDICAL INFORMATION FORM

Please make a copy of all forms for your personal records.

ATHLETES

It is your responsibility to make a copy of this form and send it to the Athletic Department and send the original to the Health Center.

Date of Admission:

Summer_____Spring_____Fall_____20_____ ___Check here if you are an International student

Student Information:

___Male_____Female

Name:_____
Last First Middle Name

Home Address:_____
Street

City State Zip Code

Phone: (Area Code)_____Cell:_____

Date of Birth:_____

CWID: _____

Citizen of: ___USA Other _____
Name of Country

Emergency Notification:

Name:_____

Relationship:_____

Address:_____
Street

City State Zip Code

Home Phone: (Area Code)

Cell Phone: (Area Code): _____

Work Phone: (Area Code)_____

It is MANDATORY that ALL F-1VISA International Students and ALL NCAA Athletes must show proof of Health Insurance.

ALL STUDENTS PLEASE PROVIDE YOUR **CURRENT** HEALTH INSURANCE INFORMATION:

Insurance Company Name: _____

Insurance Company Address: _____

Policy Holder's Name:_____ DOB:_____

Policy Holder's Home Address:_____

Policy Number:_____(ID Number) Group Number:_____

I hereby give permission to the University Wellness Center Nurse/Nurse Practitioner or MD Physician of his/her choice, to prescribe necessary medication and/or perform treatments necessary in the best interest of my health needs. I understand that my parents or guardians will be notified of any serious illness or hospitalization (Only incoming students under 18 years of age must have medical information form notarized).

_____ _____
(Signature of Student) (Date) (Signature of Parent or Guardian of Minor)

California University of Pennsylvania Student Health Center Office Use Only

Insurance Information Complete? ___Yes ___No CWID#_____

Medical Information Form and Physical Exam Complete? ___Yes ___No

Record is incomplete or requires follow-up for:
PPD:_____Hx:_____Physical:_____ Form Reviewed By_____

Personal Health History

_____ CWID # _____

(Last Name) (First Name) (Middle Name)

Do you or have you ever had?	Yes	No
Rheumatic/Scarlet Fever		
Measles (Rubeola))		
German Measles (Rubella)		
Mumps		
Chicken Pox		
Tuberculosis		
Diabetes		
Heart Disorders		
High or Low Blood Pressure		
Kidney Disorders		
Tumor/Cancer		
Hepatitis (Specify Type)		
Epilepsy/Seizure Disorder		
Mononucleosis		
Stomach/Intestinal diseases		
(specify)		
HIV/AIDS		
Eye disorders/disease		
Recurrent Sinusitis		
Recurrent ear infections		
Seasonal allergies		
Asthma		
Allergy injections		
Thyroid Conditions		
Sickle Cell Anemia		
COVID-19		
Other		

Have you been treated or hospitalized for:	Yes	No
Anxiety		
Depression		
Hyperactivity/ADD		
Bipolar illness		
Eating disorders		
(Specify)		
Head injury		
Other		
Surgical Procedures:		
Appendectomy		
Tonsillectomy		
Other:		
Bone/joint surgery/disease		
(Specify)		
Allergies to Medicines:		
(Specify)		
Allergies to Food & Additives:		
(Specify)		

FAMILY HISTORY

Have any of your relatives had any of the following conditions?

	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis				Cancer (Specify)			
Diabetes				Asthma			
Kidney Disease				Epilepsy			
Heart Disease				Alcohol/Drug Abuse			

Remarks and Additional Information: _____

_____

_____

Immunization Record

	CWID#
(Last Name) (First Name) (Middle Name)	

IMMUNIZATION REQUIREMENTS

Due to the regular incidence of dangerous communicable diseases on college campuses, the American College Health Association has asked that all colleges and universities institute an immunization policy which would require proof of sufficient immunity prior to class registration. In keeping with this, the California University Student Health Center has developed immunization requirements which must be met prior to class registration.

Measles (Rubeola) Immunization must be performed with "live" measles vaccine on or after the first birthday. If born in or after 1957, documentation of a second dose of vaccine is required. Administration of a second MMR II is recommended by the CDC. A history of the disease is not adequate proof of immunity. Mumps Immunization must be performed after the first birthday.

Primary and secondary schools in all states now require current immunizations. You may contact your high school for a copy of your immunization record. We thank you for your cooperation.

***Waiver of these immunization requirements occurs only in case of medical contradiction, documented by your physician or religious objection, documented by your religious leader.**

PLEASE COMPLETE

Tuberculin Skin Test
PPD by Mantoux Method

Date of test: _____ Time: _____

Mandatory (within the past 12 months)

Mandatory Signature

Date of reading: _____ Time: _____

Negative_____mm _____

Positive_____ mm_____

Treatment: _____

Mandatory Signature

or

Chest X-ray Date:_____
Negative… _____
Positive… _____

Treatment:_____

Mandatory Signature

Immunization Record Please List All Dates	**Date of Last Immunization**
DPT -	
Polio -	
MMR I -	
MMR II -	
Measles(Rubeola) -	
Mumps -	
Rubella (German Measles) -	
Varicella (Chickenpox) -	
Tetanus - Td (within the last 10 years)	
COVID-19 (HIGHLY RECOMMENDED)	
Hepatitis B (RECOMMENDED) - List Dates Dose 1:____ Dose 2:___ Dose 3: _____	
Meningitis Vaccine – (ACWY) Date:	
Meningitis B Vaccine: Dose 1:_____ Dose 2:_____Dose 3: _____	
HPV Vaccine (Gardasil) Dose 1:_____Dose 2:_____ Dose3:_____	
**** Athletes:*** Sickle Cell Testing - Positive_____Negative _____	**Testing Date**

****Pennsylvania State Law requires ALL students residing in residence halls provide proof of meningitis vaccine or sign a waiver.***

****Effective August 1, 2012 Sickle Cell testing is mandated for all athletes. Athletes will need to take a test, provide proof that they have already taken a test, or sign a waiver to opt out.***

THIS SECTION IS FOR YOUR PHYSICIAN TO COMPLETE

Physical Examination

_____ CWID# _____

(Last Name) (First Name) (Middle Name)

Male Female

BP:_____/_____ Ht:_____ Wt:_____lbs.

Corrected Vision: R20/ L 20/ Uncorrected Vision: R20/ L20/

Assessment of Hearing Acuity: Assessment of Dental Hygiene:

Medications (List Each Dosage) 1:_____Dosage_____

2:_____Dosage_____

3:_____Dosage_____

Drug Allergies:_____Type of Reaction:_____

_____

Is there loss or seriously impaired function of any organ? Yes_____No_____

General Comments?_____

Recommendations for physical activity (Physical Education, Athletics, etc.) Unlimited:_____Limited:_____

Explain:_____

Is the patient now under treatment for any medical or emotional condition? Yes_____No_____

If yes, please explain:_____

Do you have any recommendations regarding the care of this student? Yes_____No_____

If yes, please explain:_____

Are there any abnormalities of the following systems? Describe fully. Use an additional sheet if necessary.

	Yes	No
Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		

	Yes	No
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		

Comments:_____

_____

_____

_____ Date:_____

(Physician's Signature)

_____

(Physician's Name - Printed)

Address:_____ Phone#:_____