



Marywood

U N I V E R S I T Y

Where Learning Becomes Leading.

STUDENT HEALTH SERVICES

HEALTH HISTORY

PHYSICAL EXAMINATION

IMMUNIZATION RECORD

It is **MANDATORY** for **ALL RESIDENT STUDENTS**
to submit this form in its entirety
BEFORE the beginning of the semester.

PLEASE RETURN COMPLETED FORM TO:

Marywood University Health Services
2300 Adams Avenue
Scranton, PA 18509

Marywood University Health Services

Scranton, PA 18509

(570) 348-6249 • Fax (570) 961-4735

HEALTH HISTORY

You have been accepted to Marywood University. This information is CONFIDENTIAL and is to be used strictly by the Health Services as an aid in providing health care. No information will be released without your knowledge and written consent.
PLEASE COMPLETE THIS PORTION BEFORE GOING TO YOUR HEALTH PROVIDER.

Last Name	First	Middle	Date of Birth	I.D. Number
Home Address	City/Town	State	Zip Code	Phone Number
Next of Kin to be Contacted in Emergency			Relationship	Phone Number
Business Address				Business Phone Number

Sex _____
 S M Other

 Marital Status

 Major

Health Company _____ No Coverage
 Insurance Policy # _____
 Provider Name of Insured: _____

FAMILY HISTORY					
	Age	Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Personal Medical History. Have you ever had...? Check yes if applicable.

HAVE YOU HAD?	YES		YES		YES		YES
Scarlet Fever		Asthma		Fainting		Hepatitis	
Measles		History of Strep		Surgery		Infectious Mono	
German Measles		Throat Infection		Appendectomy		Kidney Disease	
Mumps		Bleeding Tendency		Tonsillectomy		Urinary Tract Infection	
Chicken Pox		Sinusitis		Hernia Repair		Skin Disorder	
Allergy		Dental Problems		Other		Stomach-Intestinal Problems	
Penicillin		Diabetes		Emotional Problems		Colitis	
Sulfa		Hypoglycemia		Epilepsy		Ulcer	
Serum		Disease of Bone		Seizure Disorder		Diarrhea Recurrent	
Foods		Joint injury		Head Injury with		Substance Abuse -Alcohol/Drugs	
Insects		Knee-Back		Unconsciousness		Tuberculosis	
Other (specify)		Eye,Ear,Nose		Headaches (Migraine)		Thyroid Disorder	
Anemia		Throat Problem		Heart Disease -		Tumor - Cancer - Cyst	
High Blood Pressure		Eating Disorder		Mitral Valve prolapse		Sexually Transmitted Disease	
Chronic Cough		Anorexia		Murmur		Females: Irregular or	
Bronchitis		Bulimia		Rheumatic Fever		Disabling Period	

Are you currently taking any prescribed medications? Yes _____ No _____

If yes, please list with dosage required: _____

*OPTIONAL:

Do you require accommodation to a disability? If so, please give specifics on the accommodations required in the space below or attach letter of explanation.

We would like to share information with the appropriate offices on campus. Please check this box if we have your authorization to do so.

Authorization for Treatment: I hereby authorize the Marywood health provider to treat _____ for any illness or accident deemed necessary by the university health provider. I understand that in case of serious medical emergency, every effort will be made to contact me. I will be responsible for all bills incurred.

Signature of Student _____ Date _____

Signature of Parent or Guardian _____ Date _____

PHYSICAL EXAMINATION

THIS SECTION IS TO BE COMPLETED BY HEALTH PROVIDER

Last Name _____	First _____	Middle _____	Sex _____
Blood Pressure ____/____	Pulse ____/____	Height _____	Weight _____
Visual Acuity _____	(R) 20 / _____	(L) 20 / _____	

SYSTEMS REVIEW

	Normal	Abnormal	Describe Abnormalities
Skin	_____	_____	_____
HEENT	_____	_____	_____
Lymph Nodes	_____	_____	_____
Neck	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Respiratory	_____	_____	_____
Gastrointestinal	_____	_____	_____
Genitourinary	_____	_____	_____
Reproductive	_____	_____	_____
Endocrine	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neuro/Psych	_____	_____	_____

GENERAL COMMENTS:

Is there any loss or seriously impaired function of any paired organ? Yes _____ No _____

Recommendations for physical activity (PE, Intramurals)

Unlimited _____ Limited _____ Explain: _____

Do you have any recommendations regarding the care of this patient? _____

Is this patient now under treatment for any medical or emotional condition? _____

This patient is free of communicable disease.

HEALTH PROVIDER'S SIGNATURE _____

DATE _____

Health Provider's Name (please print) _____

Address: _____

Telephone Number: (_____) - _____ Fax: (_____) - _____

IMMUNIZATION RECORD

Last Name First Middle

IMMUNIZATIONS MUST BE UPDATED AS SPECIFIED BELOW. (To be completed and signed by a health care provider)

A. TETANUS-DIPHTHERIA

- 1. Completed primary series of tetanus-diphtheria immunizations _____
Date
- 2. Received tetanus-diphtheria booster within the last 10 years _____
Date

B. M.M.R. (Measles, Mumps, Rubella)

- 1. Dose 1 - Immunized at 15 months or after and before 5 years _____
Date
- 2. Dose 2 - Immunized at 5 years or later _____
Date

C. SPECIFIC REQUIREMENTS - for Nursing/Dietetic/Physician Assistant Student prior to Clinical Assignments, and Athletic Training prior to attending first A.T. class.

- 1. Rubella Titer _____
Date
A copy of the laboratory report **MUST BE** submitted to Health Services
If not immune, must be vaccinated _____
Date
- 2. Rubeola Titer (Dietetic students only) _____
Date
- 3. Hepatitis B Vaccine (three doses or a positive Hepatitis B surface antibody titer meets the requirements.)
1 _____
Date
2 _____
Date
3 _____
Date
- 4. Varicella
History of disease _____
Vaccine Date

D. TUBERCULOSIS Screening (PPD required regardless of prior BCG inoculation. Two Step required for all Nutrition and Dietetic students and all sophomore Nursing students.)

- 1. PPD (Mantoux) test within the past year (**Tine or monovac not acceptable**)
Give date and test results Date/Month/Year _____ Result: Positive Negative
- 2. Positive PPD - **Chest x-ray required. Must submit a copy of the chest x-ray reading.**

E. POLIO

- 1. Completed primary series of polio immunization Yes No
Type of vaccine: Oral Inactive E-IPV
Last Booster _____
Date

F. MENINGOCOCCAL (Any student less than 25 years who wishes to reduce their risk of disease should consider the vaccine. Students with immunodeficiency such as complement deficiency or asplenia should receive the vaccine q3-5 yrs. Pennsylvania law mandates that **ALL students living in university owned housing be immunized or sign a waiver after receiving information on the disease and vaccine)**

- 1. Vaccine _____
Date

HEALTH CARE PROVIDER

Name: _____ Address: _____

Signature: _____ Phone: () _____