



**LOCK HAVEN UNIVERSITY**

**FORM MUST BE COMPLETED IN ENGLISH**

Student Health Services  
Lock Haven, PA 17745  
Phone: 570/484-2276  
Fax: 570/484-2522

**STUDENT INFORMATION, MEDICAL HISTORY, AND PHYSICAL REPORT  
SUBMISSION OF THIS FORM IS MANDATORY!**

The information on this form is for the use of Health Services and will not be released to anyone without your knowledge and consent except as permitted by the Family Education Rights and Privacy Act of 1974 and Health Insurance Portability & Accountability Act of 1996 (HIPAA) or as required by law.

**Date of Entrance:** Summer Spring Fall 20 \_\_\_\_  
(circle one)

**Student Name** \_\_\_\_\_  
Last First Middle

**Home Address** \_\_\_\_\_ **Home Telephone:** \_\_\_\_/\_\_\_\_\_  
Number and Street Area Code

\_\_\_\_\_  
City Country Zip code

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Sex:**  Male  Female  
Month Day Year

**EMERGENCY CONTACT**

**Name:** \_\_\_\_\_ **Phone#:** \_\_\_\_\_

**Relationship to student:** \_\_\_\_\_

**PLEASE KEEP A COPY OF THIS MEDICAL RECORD REPORT FOR YOUR RECORDS!!!**

**FAXED HEALTH FORMS ARE NOT ACCEPTABLE**

**RETURN ORIGINAL COMPLETED FORM TO:** LOCK HAVEN UNIVERSITY  
GLENNON HEALTH SERVICES  
LOCK HAVEN, PA 17745  
USA



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

**PHYSICIAN'S HEALTH EVALUATION**

(Must be completed within the past year)

**Examination Date:** \_\_\_\_\_

**TO THE EXAMINING PHYSICIAN:**

Please review the student's medical history and complete this form, commenting on all positive answers. Information will be used as a background for providing appropriate health care.

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ HR \_\_\_\_\_

2. VISUAL ACUITY: Left \_\_\_\_\_ Right \_\_\_\_\_ CORRECTION: with OR without (**PLEASE CIRCLE**)

**3. CLINICAL EVALUATION:**

**NORMAL (Check each item in appropriate column)**

**ABNORMAL (Please Explain)**

	<b>NORMAL (Check each item in appropriate column)</b>	<b>ABNORMAL (Please Explain)</b>
	Head, face, neck, and scalp	
	Eyes (acuity) and ophthalmic exam	
	Ears/Nose/Throat/Sinuses/Mouth	
	Lungs and chest	
	Heart	
	Abdomen	
	Extremities/Spine/Musculoskeletal	
	Skin	
	Neurological	
	G-U	
	Menstrual History (if applicable)	

4. Does student have any medical conditions? (Please explain) \_\_\_\_\_

5. Has student ever been treated for emotional or mental disorders? (eg: depression, anxiety, or eating disorders. Please explain)

6. List any current medications: \_\_\_\_\_

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

**IMMUNIZATIONS: PLEASE NOTE YOU WILL NOT BE ABLE TO ATTEND CLASSES WITHOUT COMPLETING THIS SECTION! \*FAILURE TO COMPLY WITH THE REQUIREMENTS WILL PREVENT THE STUDENT’S ENROLLMENT FOR THE NEXT SEMESTER \***

**THE FOLLOWING IMMUNIZATIONS ARE ENTRANCE REQUIREMENTS:**

1. TETANUS (within last 10 years).....Date Received \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

2. POLIO (IPV or OPV) series of three and booster or submit a written copy of titer results.

(1) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (2) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (3) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Booster: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year Month Day Year Month Day Year Month Day Year

**3. MEASLES, MUMPS, AND RUBELLA (MMR):**

LHU requires that all entering college students born after 1956 have two (2) doses of the live measles vaccine and one (1) each for mumps and rubella in order to keep in compliance with the American College Health Association Guidelines.

MMR #1: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OR MEASLES (Rubeola): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MUMPS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RUBELLA \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year Month Day Year Month Day Year Month Day Year

MMR #2: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ OR MEASLES (Rubeola) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year Month Day Year

Please submit a written copy of blood titer if you are unable to provide documentation of dates of immunization. Consult your physician to have these laboratory tests completed.

MEASLES: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ MUMPS: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RUBELLA \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year Month Day Year Month Day Year

**4. TUBERCULOSIS (TB) SCREENING TEST\_– (Required within 6 months prior to admission)**

A. PPD (Mantoux) Date Received: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SITE: \_\_\_\_\_  
Month Day Year

Date Read: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ RESULTS: \_\_\_\_\_ mm negative \_\_\_\_\_ mm positive  
Month Day Year

\_\_\_\_\_  
Signature of RN/MD

B. Chest x-ray required for positive PPD \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Results: \_\_\_\_\_ Negative  
Month Day Year \_\_\_\_\_ Positive

**(PLEASE PROVIDE WRITTEN DOCUMENTATION OF CHEST X-RAY)**

C. Treatment received for positive PPD/CXR: (please explain): \_\_\_\_\_

5. CHICKEN POX: DATE OR AGE OF DISEASE \_\_\_\_\_ OR VACCINE DATE(S) 1. \_\_\_\_\_  
2. \_\_\_\_\_

NAME \_\_\_\_\_

**6. MENINGITIS VACCINATION**

**PA. STATE LAW REQUIRES THAT COLLEGE STUDENTS ARE ADVISED OF THE RISKS ASSOCIATED WITH MENINGOCOCCAL DISEASE AND THE AVAILABILITY/EFFECTIVENESS OF THE VACCINE. ALL STUDENTS LIVING IN A RESIDENCE HALL MUST PROVIDE PROOF OF THE VACCINATION OR A WRITTEN WAIVER BEFORE OCCUPANCY WILL BE PERMITTED.**

A. MENINGITIS VACCINATION \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year

**7. HEPATITIS B IMMUNIZATION**

1. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 2. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 3. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Month Day Year Month Day Year Month Day Year

**Important Information which you may find to be useful in obtaining acceptable record of your immunization:**

- 1. High School**—Contact your high school nurse for a copy of your immunization record.
- 2. Personal Immunization Record**—Records from pediatrician or family physician are acceptable, if verified (stamp and signature) and if they contain proof of minimum requirements.
- 3. Local Health Department**— If primary immunizations were received at a local health department, a copy can be acquired from this source.
- 4. Transfer Students**— If the college/university you previously attended had immunization requirements, it is possible that these records will be acceptable proof of immunization.
- 5. Immune Titers**—IF YOU ARE UNABLE TO LOCATE ANY OF YOUR MEASLES/MUMPS/RUBELLA IMMUNIZATION DATES, CONTACT YOUR PHYSICIAN FOR LABORATORY BLOOD TITER TESTS. SUBMIT A WRITTEN COPY OF THESE RESULTS ALONG WITH THIS MEDICAL HISTORY FORM.

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**THIS SECTION IS TO BE COMPLETED FOR NCAA ATHLETES ONLY: MANDATORY ORTHOPEDIC ASSESSMENT**

\_\_\_\_\_ is cleared to participate in the following: \_\_\_\_\_  
(STUDENT'S NAME) (SPORT)

JOINT	RIGHT	LEFT	COMMENTS
Ankle			
Knee			
Hip			
Back/Spine			
Shoulder			
Elbow			

NAME \_\_\_\_\_

**PHYSICIAN'S REPORT**

I certify that I am a physician legally qualified to practice medicine in the country of \_\_\_\_\_,

and I have examined the above named student; that the above statements are correct; and that I find the student is neither mentally nor physically disqualified by reason of tuberculosis or any chronic or acute defect from successful performance as a college student, except as noted above.

\_\_\_\_\_  
(Examining Physician's Signature) (Address)

\_\_\_\_\_  
(Print Name) (City) (Country)

\_\_\_\_\_  
(Zip)

\_\_\_\_\_  
(Phone Number) (Fax Number)

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**If you have any questions about the information requested on this form, please email Nursing Supervisor Kim Wetzel at [kwetzel@lhup.edu](mailto:kwetzel@lhup.edu)**

**SECTION IV: COMPLETION OF INSURANCE INFORMATION IS MANDATORY FOR ALL STUDENTS**

(This page is for American students ONLY. International students should complete section V).

Attach a copy of all medical/dental insurance cards to this form (front & back). Please print.

**FOR HMO PARTICIPANTS, PLEASE INVESTIGATE HOW TO HANDLE OUT OF SERVICE NETWORK HEALTH CARE OR REFERRALS FOR YOUR CHILD! PLEASE BE ADVISED THAT OFFICE CALLS ARE FREE AT HEALTH SERVICES. IT IS THE STUDENT'S RESPONSIBILITY TO OBTAIN ANY REFERRAL NECESSARY FOR INSURANCE COVERAGE.**

**STUDENT'S NAME:** \_\_\_\_\_  
Last First Middle

**DATE OF BIRTH:** \_\_\_\_\_ **SS#:** \_\_\_\_\_ **HOME PHONE ( )** \_\_\_\_\_

**HOME ADDRESS:** \_\_\_\_\_ **CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**PRIMARY INSURANCE:**

**NAME OF PERSON WHO CARRIES YOUR INSURANCE (GUARANTOR)** \_\_\_\_\_ **D.O.B.** - -

**RELATIONSHIP TO STUDENT** \_\_\_\_\_

**GUARANTOR'S SS#** \_\_\_\_\_ **PHONE # ( )** \_\_\_\_\_

**GUARANTOR'S ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**GUARANTOR'S EMPLOYER** \_\_\_\_\_

**INSURANCE COMPANY NAME** \_\_\_\_\_

**INSURANCE CO. ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**INSURANCE CO. NUMBERS: GROUP** \_\_\_\_\_ **ID** \_\_\_\_\_ **TYPE OF BC/BS** \_\_\_\_\_

**PRE-CERTIFICATION PHONE NUMBER ( )** \_\_\_\_\_

**MEMBER SERVICE PHONE NUMBER ( )** \_\_\_\_\_

**SECONDARY INSURANCE:**

**NAME OF PERSON WHO CARRIES YOUR INSURANCE (GUARANTOR)** \_\_\_\_\_

**RELATIONSHIP TO STUDENT** \_\_\_\_\_

**GUARANTOR'S SS#** \_\_\_\_\_ **PHONE # ( )** \_\_\_\_\_

**GUARANTOR'S ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**GUARANTOR'S EMPLOYER** \_\_\_\_\_

**INSURANCE COMPANY NAME** \_\_\_\_\_

**INSURANCE COMPANY ADDRESS** \_\_\_\_\_ **CITY** \_\_\_\_\_ **STATE** \_\_\_\_\_ **ZIP** \_\_\_\_\_

**INSURANCE COMPANY NUMBERS: GROUP** \_\_\_\_\_ **ID** \_\_\_\_\_ **TYPE OF BC/BS** \_\_\_\_\_

**PRE-CERTIFICATION PHONE NUMBER ( )** \_\_\_\_\_

**MEMBER SERVICE PHONE NUMBER ( )** \_\_\_\_\_

