

LOCK HAVEN UNIVERSITY MEDICAL HISTORY FORM

- **SUBMISSION OF THIS FORM IS MANDATORY FOR ALL STUDENTS!!!!**
- **ALL STUDENTS WISHING TO PARTICIPATE IN NCAA ATHLETICS AT LHU MUST SUBMIT A COMPLETE MEDICAL FORM INCLUDING THE NCAA REQUIRED CLEARANCE. (PAGE 5 - SEC. A).**
- **RETURN COMPLETED FORM TO: LOCK HAVEN UNIVERSITY • GLENNON HEALTH SERVICES
401 N. FAIRVIEW ST • LOCK HAVEN, PA 17745
PHONE: (570) 484-2276 • FAX: (570) 484-2522**

DATE OF ENTRANCE: SUMMER SPRING FALL 20_____		CITIZENSHIP: <input type="checkbox"/> US <input type="checkbox"/> OTHER	
(CIRCLE ONE)			
LAST NAME	FIRST NAME	MI	D.O.B
HOME ADDRESS (STREET AND NUMBER)			
CITY		PHONE: ()	
STATE/COUNTRY	ZIP	CELL: ()	
EMERGENCY CONTACT:		PHONE: ()	
RELATIONSHIP		CELL ()	
SPORT:	<input type="checkbox"/> MEN <input type="checkbox"/> WOMEN	MAJOR:	

INSURANCE INFORMATION (REQUIRED): ATTACH A COPY OF **ALL** MEDICAL/DENTAL CARDS (FRONT & BACK) TO THE FORM. L.H.U. HEALTH SERVICES IS NOT RESPONSIBLE FOR ANY COSTS NOT COVERED BY INSURANCE. PLEASE CHECK IF YOUR INSURANCE IS COVERED IN THIS AREA.

LAST NAME	FIRST NAME	MI	D.O.B
HOME ADDRESS (STREET AND NUMBER)		CITY	
STATE/COUNTRY	ZIP	PHONE: ()	
NAME OF PERSON WHO CARRIES YOUR INSURANCE (GUARANTOR)		D.O.B.	SS#
RELATIONSHIP TO STUDENT			
INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS	
CITY		STATE/COUNTRY	ZIP
INSURANCE CO. GROUP #	ID#	PLAN	HMO <input type="checkbox"/> PPO <input type="checkbox"/> TRADITIONAL <input type="checkbox"/>
PRECERTIFICATION PHONE #		MEMBER SERVICE PHONE #	

OFFICE USE ONLY

LOCAL ADDRESS		
CITY	STATE	PHONE/CELL
ID#	DATE RECEIVED:	

NAME:	D.O.B.
-------	--------

PERSONAL HEALTH HISTORY (MUST BE COMPLETED BY THE STUDENT)

LIST ANY MEDICATIONS YOU ARE TAKING?

--	--	--	--

ARE YOU **ALLERGIC** TO ANY MEDICATIONS: YES NO If yes, list medication(s) and reactions:

--	--	--	--

ARE YOU **ALLERGIC** TO ANY FOOD, ADDITIVES &/ OR INSECTS: YES NO List below:

--	--	--	--

Have you ever had:	YES	NO	Have you ever had:	YES	NO	Have you ever had:	YES	NO
Hepatitis A,B, or C (Circle)			Reactive Airway Disease (asthma)			Attention Deficit Disorder		
HIV Status			Pneumonia			Bipolar Disease		
Mononucleosis			Sinusitis			Depression		
Chicken Pox			Seasonal Allergies			Anxiety		
Measles (Rubeola)			Shortness of Breath/fatigue (esp. with exercise)			Panic Attacks		
Mumps			Unexplained fainting (esp. with exercise)			Suicide Attempts		
German Measles (Rubella)			Thyroid Disease			Learning Disability		
Tuberculosis			Diabetes			Eating Disorder		
Rheumatic/Scarlet fever			Hypoglycemia			Psychiatric Problems (List)		
Gallbladder Disease			Arthritis			Alcohol/Drug Dependency		
Gastroesophageal Reflux Disease (GERD)			Back Problems			FEMALE		
Liver Disease: explain			Headaches (Type)			Ovarian Cysts		
Inflammatory Bowel Disease			Seizure Disorder			Breast Disease		
Polyps (Colon)			Multiple Sclerosis			Pelvic infections		
Heart Disease, Heart Murmur or Heart Infection Explain:			Cancer			Past Pregnancy		
High/Low Blood Pressure			Tumor/Cyst: Benign Malignant			Irregular Periods		
Chest pain/discomfort upon exertion						Excessive Cramping		
Eye Disorders/Disease Describe:			Physical Disabilities Describe:			MALE		
Ear Disorders/Disease Describe:			Any surgeries Describe:			Hernia		
Dental disorders			Any broken bones:			Testicle Problems		

FAMILY HISTORY Have any of your blood relatives had any of the following:

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Arthritis				High Blood Pressure				Kidney Disease			
Reactive Airway Disease(asthma)				Seizure Convulsions				Diabetes			
Tuberculosis				Cancer				Alcohol/Drug Dependency			
Heart Disease – i.e. Heart murmur, hypertrophy, irregular heart beat, Marfan’s syndrome				Sudden or Unexpected Death of a relative before age 50 due to heart disease)				Close relative <50 with disability from heart disease			

CONSENT/AUTHORIZATION FOR TREATMENT

I certify that the information provided on this Medical History Form is true and complete to the best of my knowledge. I also realize that this information is confidential and for use by the Health Service staff. I give permission for myself to be evaluated, diagnosed and treated by University Health Services under the direction of a physician. It should be understood that under certain circumstances or emergencies, I may be referred to an area hospital, diagnostic testing facility or medical specialist for evaluation, diagnosis, and/or treatment. **Costs for these services are the responsibility of the student.**

--	--	--	--

STUDENT SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE (IF STUDENT IS A MINOR UNDER 18)

NAME:	D.O.B.
-------	--------

PHYSICAL EXAMINATION (FOR ALL STUDENTS) DATE OF EXAM: ____/____/____

REQUIREMENT: PHYSICALS MUST BE COMPLETED WITHIN 1 YEAR OF ATTENDING L.H.U. **EXCEPT** STUDENTS WISHING TO PARTICIPATE IN **NCAA** ACTIVITIES. THE MEDICAL FORM MUST BE COMPLETED WITH **6 MONTHS** PRIOR TO ANY NCAA ACTIVITIES. THE MEDICAL FORM MUST BE SUBMITTED WITH THE APPROPRIATE CLEARANCE (PAGE 5-SECTION A).

T.	P.	R.	BP. /	HT.	WT.	VISION:R 20/	CORRECTED: <input type="checkbox"/> Y <input type="checkbox"/> N
						L 20/	

CLINICAL EVALUATION:

IS THE STUDENT CURRENTLY TAKING ANY MEDICATIONS? (Include Birth Control Methods and Herbal Supplements)

1. _____	Dosage _____	3. _____	Dosage _____
2. _____	Dosage _____	4. _____	Dosage _____

DOES THE STUDENT HAVE ANY ILLNESS/CONDITION NOT LISTED IN THE PERSONAL HISTORY, FOR WHICH TREATMENT IS REQUIRED? YES NO If yes, please specify below: _____

IS THE STUDENT BEING TREATED FOR EMOTIONAL/MENTAL DISORDERS: YES NO If yes, please specify below: _____

DOES THE STUDENT HAVE ANY PHYSICAL DISABILITIES OR ASSISTED DEVICES? YES NO If yes, please specify below: _____

	NORMAL	ABNORMAL FINDINGS (Please Explain)	INITIALS
MEDICAL			
Head, face, neck, and scalp			
Eyes (acuity) and ophthalmic exam			
Ears/Nose/Throat/Sinuses/Mouth			
Lungs and chest			
Heart			
Abdomen			
Skin			
Neurological			
G-U			
Menstrual History (if applicable)			
MUSCULOSKELETAL			
Neck			
Back/ shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
ATHLETICS ONLY: REQUIRED			
Heart murmur*			
Femoral pulses to exclude aortic coarctation			
Physical stigmata of Marfan syndrome			
Brachial artery BP sitting position+			

**Should be done supine and standing (or Valsalva maneuver) to identify (L) ventricular outflow obstruction*

+Preferably done in both arms

NAME:

D.O.B.

REQUIRED IMMUNIZATIONS

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. *All information must be in English.*

A. TETANUS DIPHTHERIA PERTUSSIS (The date of your last Tetanus booster must be **within the past 10 years.**)

Tdap (preferred)

DATE: ____/____/____ (MMDDYYYY) **Last Td Booster** DATE: ____/____/____ (MMDDYYYY)

B. MMR (Two doses required if born after the year 1956.)

DOSE #1 ____/____/____ (MMDDYYYY) DOSE#2 ____/____/____ (MMDDYYYY)

OR

MMR TITER: ____/____/____ RESULTS: _____ (**PROVIDE WRITTEN COPY OF TITER**)

C. POLIO (SERIES OF 3 AND A BOOSTER)

#1 ____/____/____ (MMDDYYYY) #2 ____/____/____ (MMDDYYYY) #3 ____/____/____ (MMDDYYYY)

BOOSTER ____/____/____ (MMDDYYYY)

D. VARICELLA

1. DATE OR AGE OF DISEASE: ____/____/____ (MMDDYYYY)

OR

2. IMMUNIZATION

DOSE #1 ____/____/____ (MMDDYYYY) DOSE #2 ____/____/____ (MMDDYYYY)

OR

3. VARICELLA ANTIBODY: **PLEASE PROVIDE A WRITTEN COPY OF TITER**

DATE: ____/____/____ (MMDDYYYY) RESULT: REACTIVE _____ NON-REACTIVE _____

E. HEPATITIS B

1. IMMUNIZATION

DOSE #1: ____/____/____ (MMDDYYYY)

DOSE #2: ____/____/____ (MMDDYYYY)

DOSE #3: ____/____/____ (MMDDYYYY)

OR

2. HEPATITIS B SURFACE ANTIBODY: **PLEASE PROVIDE A WRITTEN COPY OF TITER**

DATE: ____/____/____ (MMDDYYYY) RESULT: REACTIVE _____ NON-REACTIVE _____

F. MENINGOCOCCAL TETRAVALENT (Menactra or Menomune)

1. DATE RECEIVED: ____/____/____ (MMDDYYYY)

G. TUBERCULOSIS (TB) SCREENING/TESTING: MANTOUX REQUIRED WITHIN 6 MONTHS PRIOR TO BEGINNING OF CLASSES

ONLY STUDENTS FITTING ONE/BOTH OF THE FOLLOWING CATEGORIES:

CATEGORY 1

- **HIGH RISK STUDENTS** include those that have arrived or traveled* to/in high-prevalence areas within the past 5 yrs to countries where TB is endemic. **NO WAIVER FOR PRIOR BCG VACCINATION!**

EXEMPT: Students arriving from the following countries are not required to be tested:

Albania, America Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Islands, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France,

Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kittsand

Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, United States Virgin Islands, U.S.A.

CATEGORY 2 – HIGH RISK STUDENTS:

- Residents, employees, or volunteers in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities), HIV/AIDS, history of illicit drug use
- **Students who have the following clinical conditions:** Organ transplant recipient, Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- α antagonist), recent close contact with someone with infectious TB disease, fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease, Medical conditions such as diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population).

NAME:	D.O.B.
-------	--------

1. MANTOUX SKIN TEST: REQUIRED FOR ALL HEALTH SCIENCES, ATHLETIC TRAINING AND EDUCATION PROGRAMS.

DATE GIVEN: ____/____/____ (MMDDYYYY)

DATE READ: ____/____/____ (MMDDYYYY) RESULT: _____ mm of induration

OR

2. CHEST X-RAY:REQUIRED IF MANTOUX SKIN TEST IS POSITIVE (SEND WRITTEN COPY OF CHEST XRAY)

DATE ____/____/____ (MMDDYYYY) RESULT: NORMAL____ ABNORMAL____

TREATMENT— list medications with dates and duration of treatment for TB or prophylaxis for a positive PPD:

--	--	--

HEALTH CARE PROVIDER INSTRUCTIONS – to be completed by the examining physician

- **WE STRONGLY URGE YOU TO MAKE COPIES!!!**
- SECTIONS A, B, AND C MUST BE COMPLETED BY THE STUDENTS WISHING TO PARTICIPATE (PRACTICES, TRYOUTS, ETC) IN NCAAATHLETICS. (MANDATORY)
- SECTIONS B AND C MUST BE COMPLETED BY ALL OTHER STUDENTS.

A. (MANDATORY FOR ATHLETES ONLY) MEDICAL CLEARANCE TO PARTICIPATE IN NCAA ATHLETICS

<input type="checkbox"/> CLEARED WITHOUT RESTRICTION	
<input type="checkbox"/> CLEARED, WITH RECOMMENDATIONS FOR FURTHER EVALUATION OR TREATMENT FOR:	
<input type="checkbox"/> NOT CLEARED FOR <input type="checkbox"/> ALL SPORTS <input type="checkbox"/> CERTAIN SPORTS: _____	
REASON: _____	
RECOMMENDATION: _____	
SIGNATURE OF HEALTH CARE PROVIDER	LICENSE NUMBER
ADDRESS	CITY
HEALTH CARE PROVIDER	DATE

B. (ALL STUDENTS) IMMUNIZATIONS

(E.g., Tetanus/diphtheria; polio; measles, mumps, rubella; Mantoux skin test; Varicella; Hepatitis B; Meningitis)

<input type="checkbox"/> UP TO DATE (See attached document) <input type="checkbox"/> NOT UP TO DATE Specify: _____
--

C. (ALL STUDENTS) PHYSICIAN'S REPORT

I certify that I am a physician legally qualified to practice medicine in the State or 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.

SIGNATURE OF HEALTH CARE PROVIDER		LICENSE NUMBER	
ADDRESS		CITY	
STATE	ZIP CODE	PHONE	FAX
SIGNATURE OF HEALTH CARE PROVIDER (PRINT)		DATE	

This form becomes part of your permanent health file. This form must be completed by you and a physician, preferably the family physician. The information on this form is for the use of the 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.