



**LOCK HAVEN UNIVERSITY**

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

**FORM MUST BE COMPLETED IN ENGLISH  
SUBMISSION OF THIS FORM IS MANDATORY**

**STUDENT INFORMATION, MEDICAL HISTORY, AND PHYSICAL REPORT**

Date of Entrance: Summer Spring Fall 20\_\_\_\_  
(Circle One)

Student Name: \_\_\_\_\_  
Last First Middle

Home Address: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_  
Number and Street Area Code

\_\_\_\_\_  
City State or Country Zip Code

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female

**EMERGENCY CONTACT**

Name: \_\_\_\_\_ Phone#: \_\_\_\_/\_\_\_\_  
Area Code

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

RETURN ORIGINAL COMPLETED FORM TO: LOCK HAVEN UNIVERSITY  
GLENNON HEALTH SERVICES  
401 NORTH FAIRVIEW ST.  
LOCK HAVEN, PA 17745

**OFFICE USE ONLY**

LOCAL ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

LOCAL PHONE (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_

NAME: \_\_\_\_\_ D. O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_

**PERSONAL HISTORY (Must be completed by student)**

Have you had?	Yes	No	Have you been treated or hospitalized for:	Yes	No
Rheumatic/Scarlet Fever			Anxiety		
Measles (Rubeola)			Depression		
German Measles (Rubella)			Hyperactivity/ADD		
Mumps			Bipolar Illness		
Chicken Pox			Eating Disorder (specify)		
Tuberculosis (TB)			Head Injury		
Diabetes			<b>SURGICAL PROCEDURES</b>		
Heart Disorder			<b>EXPLAIN BELOW:</b>		
High or Low Blood Pressure			<b>ALLERGIES TO MEDICINE</b> <b>(DO NOT LEAVE BLANK)</b>		
Kidney Disorder					
Tumor/Cancer					
Hepatitis (Specify Type)					
Epilepsy/Seizure Disorder					
Mononucleosis					
Stomach/Intestinal Disease (specify)					
HIV/AIDS					
Eye Disorder/Disease					
Recurrent Sinusitis					
Recurrent Ear Infections			<b>ALLERGIES TO FOOD &amp; ADDITIVES</b>		
Seasonal Allergies					
Reactive Airway Disease (asthma)					
Allergy Injections					

**Family History**

Have any of your relatives had any of the following:

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

**CONSENT FOR TREATMENT**

I certify that the information provided on this Medial 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/Legal Guardian Signature Date  
(If student is a minor under 18 years old)

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.

NAME: \_\_\_\_\_ D. O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_

**PHYSICIAN'S HEALTH EVALUATION**

**Examination Date:** \_\_\_\_\_  
(Must be completed within the past year)

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)**

	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? (e.g. Depression, anxiety, or eating disorders)  
Please explain:  
\_\_\_\_\_

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

**7. FOR NURSING MAJORS ONLY \*\*\*\*\* (Please submit copies of lab tests with medical report) \*\*\*\*\***

Blood tests	Date	CBC	Results
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**8. THIS SECTION IS TO BE COMPLETED BY 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: \_\_\_\_\_ D. O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_

**IMMUNIZATIONS:**

**PLEASE NOTE ALL STUDENTS MUST HAVE THIS SECTION COMPLETED!!!!**

**\*\*\*FAILURE TO COMPLY WITH THE REQUIREMENTS WILL PREVENT THE STUDENT'S ENROLLMENT FOR THE SEMESTER.\*\*\***

**THE FOLLOWING IMMUNIZATIONS ARE ENTRANCE REQUIREMENTS FOR ALL STUDENTS:**

**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 NURSE/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: \_\_\_\_\_ D. O. B. \_\_\_\_/\_\_\_\_/\_\_\_\_

**6. HEPATITIS B IMMUNIZATION**

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

**7. 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.**

DATE RECEIVED \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
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.

**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 above.

\_\_\_\_\_  
(Examining Physician’s Signature)

\_\_\_\_\_  
(Print name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City)

\_\_\_\_\_  
(State or Country)

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

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

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

**INSURANCE INFORMATION: PLEASE PRINT**

UNITED STATES STUDENTS COMPLETE PAGE 6

INTERNATIONAL STUDENTS COMPLETE PAGE 7

ATTACH A COPY OF ALL MEDICAL/DENTAL INSURANCE CARDS TO THIS FORM (FRONT & BACK).  
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: \_\_\_\_\_

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# \_\_\_\_\_

PLAN \_\_\_\_\_ TYPE  Traditional  HMO  PPO  \_\_\_\_\_

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

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

**SECONDARY INSURANCE (IF ANY):**

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 \_\_\_\_\_ PLAN \_\_\_\_\_ TYPE  Traditional

HMO

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

PPO

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

\_\_\_\_\_

DO NOT LEAVE ANY SPACE BLANK



