# Lebanon Valley College

## HEALTH SERVICES | REPORT OF MEDICAL HISTORY

- Please complete pages 1 and 4 *before* going to your physician for an examination.
- Information you provide is used solely as an aid to providing health care, if necessary, while you are a student.
- Information is strictly for the use of Health Services and is not released to anyone without your knowledge and consent.
- Please keep a copy of this form (for your records) before submitting. Return original form to the Health Services Office.

Anticipated Major(s)____________________________________________________________________________

Anticipated Start Date __________________________________________________________________________

**Please check if applicable:**

___ **Resident**

___ **Commuter**

___ **Transfer**

**Last Name (Print)** **First Name** **Middle**

**Student Cell Phone Number** **Date of Birth**

Parent / Guardian Name(s) Relationship Phone

Address of Parent or Guardian Other Phone

Name: In Emergency Notify (if different than parent or guardian) Phone Other Phone

**FAMILY HISTORY - Does anyone in your family (parents, grandparents, siblings) have a medical condition or diagnosis? If unknown check here _____**

| Relationship | Age | State of Health | Occupation | Age at Death | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brother(s) | | | | | |
| | | | | | |
| | | | | | |
| Sister(s) | | | | | |
| | | | | | |
| | | | | | |

| | Yes | Relationship |
|---|---|---|
| Tuberculosis | | |
| Diabetes | | |
| Kidney Disease | | |
| Heart Disease | | |
| Arthritis | | |

| | Yes | Relationship |
|---|---|---|
| GI Disease | | |
| Asthma/Hay Fever | | |
| Epilepsy/Convulsions | | |
| Cancer | | |
| High Blood Pressure | | |

**PERSONAL HISTORY - Please answer all questions. Feel free to provide more information or details to health center nurse via email or paper report.**

| Have you had…… | Yes | | Yes | | Yes | | Yes |
|---|---|---|---|---|---|---|---|
| Mononucleosis | | Hepatitis | | Chicken Pox | | Gum/Tooth Trouble | |
| Sinusitis | | Eye Problem | | Hearing Difficulty | | Nose Problem | |
| Throat Problem | | Diabetes | | Seizures | | Eczema | |
| Head Injury with Unconsciousness | | Concussion Diagnosis | | Neck Injury | | Tobacco Use | |
| Acne | | Insomnia | | Anxiety | | Depression | |
| Worry or Nervousness | | Hay Fever/Allergies | | Cystic Fibrosis | | Bronchitis | |
| Pneumonia | | Tuberculosis | | Shortness of Breath | | Asthma | |
| Disease or Injury of Joints | | Back Problems | | Malaria | | **Anemia** | |
| Heart Palpitations | | Chest Pain | | High/Low Blood Pressure | | Rheumatic Fever | |
| Heart Murmur | | Weakness, Paralysis | | Dizziness or Fainting | | Other Heart Condition | |
| Intestinal/Stomach Trouble | | Recurrent Diarrhea | | Recurrent Constipation | | Recent Weight Gain or Loss | |
| Bladder infection | | Kidney Infection | | Jaundice | | Gallbladder Trouble | |
| Tumor, Cancer, Cyst | | Bleeding Disorder | | Thyroid Problem | | Hernia | |
| Sexually Transmitted Infection | | Irregular Periods | | Severe Periods | | Excessive Flow | |
| Abnormal Pap Smear | | Current Pregnancy | | Cystic Breasts | | Prostate Problems | |
| Lump or Mass in Testicles | | | | | | | |

**** Student athletes must complete a separate physical form per athletics department requirements. ****

# LEBANON VALLEY COLLEGE HEALTH SERVICES | PHYSICIAN'S REPORT OF HEALTH EVALUATION

**TO HEALTH CARE PROVIDER: Please complete the provider's report in English. Please comment on all positive answers. THIS STUDENT HAS BEEN ACCEPTED. The information supplied will not affect his/her status. All items marked with an asterisk (*) are REQUIRED and must be complete or the form will be returned for completion. Physical MUST be completed within one (1) year prior to the student's arrival on campus.**

______________________________________________________________________
Last Name (Print) First Name Middle Date of Birth

*B/P________________ *P________________ *R ________________ *Height (inches)__________ *Weight (lbs.) __________

*Current Medications and Dosage: ______________________________________________________________________

______________________________________________________________________

*Allergies: ______________________________________________________________________

Please assess the following systems. Please describe any abnormalities fully in comments section.

| System | Normal | Abnormal | Comments |
|---|---|---|---|
| Cardiovascular | | | |
| Eyes | | | |
| Gastrointestinal | | | |
| Genitourinary | | | |
| Head, Ears, Nose or Throat | | | |
| Hematologic/Immunologic | | | |
| Hernia | | | |
| Metabolic/Endocrine | | | |
| Musculoskeletal | | | |
| Neuropsychiatric | | | |
| Respiratory | | | |
| Skin | | | |

Is the patient currently under treatment for any medical or psychological condition? _____ Yes _____ No

If yes, explain:______________________________________________________________________

Does the student have any physical disabilities or assistive devices? _____ Yes _____ No

If yes, explain:______________________________________________________________________

□ **CLEARED** for full activity ______________________________________________(list sport if playing in college)

□ **CLEARED WITH RECOMMENDATION(S)** for further evaluation or treatment for: ______________________________

□ **NOT CLEARED** for the following types of sports (please check those that apply):

□ **COLLISION** □ **CONTACT** □ **NON-CONTACT** □ **STRENUOUS** □ **MODERATLEY STRENUOUS** □ **NON-STRENUOUS**

Do you have any recommendations regarding the care of this student, not previously addressed? ____ Yes ____ No

If yes, explain:______________________________________________________________________

## *Healthcare Provider Information (Physician, CRNP, PA-C)

Name ______________________________________ Phone # ______________________________

Address ______________________________________ Fax # ______________________________

Signature ______________________________________ Date ______________________________

***Review immunization and PPD requirements on the following page.**

Last Name (Print) | First Name | Middle | Date of Birth

## HEALTH SERVICES | PREADMISSION IMMUNIZATION POLICY

*All incoming freshmen, transfer students and foreign exchange students, whether commuter or residential, are required to verify the immunization guidelines below before matriculating at Lebanon Valley College.

NOTE: ITEMS MARKED WITH AN ASTERISK (*) ARE MANDATORY; INCOMPLETE OR INCORRECT IMMUNIZATION REPORTS WILL BE REJECTED.

| VACCINE | DATE(S) |
|---|---|
| *** Diphtheria/Tetanus/Pertussis**<br>Usually given as DTP or DT or TD | |
| ***DTaP/Adacel/Boostrix (Circle)**<br>(Booster in last 10 years) | |

| VACCINE | DATE(S) |
|---|---|
| ***MMR**<br>2 doses or immune titer - attach copy | |
| **OR** | |
| **Measles**<br>Usually given as MMR | |
| **Mumps**<br>Usually given as MMR | |
| **Rubella**<br>Usually given as MMR | |

| VACCINE | DATE(S) |
|---|---|
| **Hepatitis A** | |
| ***Hepatitis B**<br>**(series of 3)** | |
| **HPV** | |

| VACCINE | DATE(S) |
|---|---|
| ***Varivax vaccine**<br>2 doses or immune titer - attach copy | |
| **Varicella Disease (age or date)** | |

| *TUBERCULOSIS: required PPD FOR ALL STUDENTS | |
|---|---|
| Tuberculosis Testing within the last 12 months* required regardless of prior BCG inoculation<br>**Date Given:**__________<br>**Date Read:** __________<br>**Result:** ___ Neg ___ Pos<br>Induration _________mm<br>**-OR-**<br>Quantiferon Gold (IGRA)<br>**Date**______________<br>**Result:** ___ Neg ___ Pos | **If positive PPD or prior history of +PPD: Chest x-ray required within last 2 years**<br>**CXR Date**____________ **Results:**<br>____ Normal<br>____ Abnormal<br>**Drug** Therapy**:** Drug used____________<br>**Dates:**__________ **to** ___________ |
| **PPD given by:** | **PPD results read by:** |

| VACCINE | DATE(S) |
|---|---|
| ***Meningococcal**<br>**(Menactra)(A/C/Y/W-135)**<br>(Per CDC guidelines: if primary dose administered before age 16, then a booster is required.) | |
| **Meningitis B**<br>**(Recommended but not required)** | |

| VACCINE | DATE(S) |
|---|---|
| **COVID-19 Vaccine**<br>**Manufacturer:** ______________ | |
| Submit copy of completed vaccine card along with this form | |

Last Name (Print) First Name Middle Date of Birth

## LEBANON VALLEY COLLEGE HEALTH SERVICES | INSURANCE INFORMATION

**All students residing at Lebanon Valley College are required to have health insurance.**
Please provide insurance information below.
Report any changes in insurance during your time at LVC to the Health Center nurse.

Name of Insurance Company ______________________________

Name of Policy Holder ______________________________

Insurance Company Address ______________________________

______________________________

Insurance Company Telephone ( ) ______________________________

Group Number ______________ ID/Certificate Number ______________

Name of Primary Care Physician ______________________________

Physician Telephone ( ) ______________________________

## HEALTH SERVICES | CONSENT FOR TREATMENT

Complete only if student is a minor upon entrance to LVC.

Parental permission must be obtained before medical treatment can be rendered to persons ***under 18 years of age***. The following consent form should be signed by a parent or guardian so that indicated care might be given with no unnecessary delay. No major procedures will be performed except in extreme emergency, without parents being notified and fully informed. Please choose give or refuse below.

"I give / refuse (PLEASE CIRCLE ONE) permission to the Health Center nurse of Lebanon Valley College to render emergency care and other medical care in line with LVC policies and standing orders. I also permit such procedures to be carried out at and by one of the local hospitals in the event that my son/daughter has been sent or taken there for emergency care."

______________________________ Parent/Guardian Signature ______________ Relationship

______________________________ Student Signature ______________ Date

Attention Student

**** Please make a copy of this entire form (for your records) before submitting and return the original form to the Health Services Office. ****

**Return to: Health Services Office, Lebanon Valley College, 83 E Sheridan Ave, Annville, PA 17003-1400 | Fax: 717-867-6895**
**Or by secure electronic upload through the New Student Portal**
**Deadlines: August 1 for fall registration | January 1 for spring registration**