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.

Please check if applicable:
___ **Resident**
___ **Commuter**
___ **Transfer**

Anticipated Major(s)_____
Anticipated Start Date _____

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** Usually given as DTP or DT or TD	
***DTaP/Adacel/Boostrix (Circle)** (Booster in last 10 years)	

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

VACCINE	DATE(S)
Hepatitis A	
***Hepatitis B (series of 3)**	
HPV	

VACCINE	DATE(S)
***Varivax vaccine** 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 **Date Given:**_____ **Date Read:** _____ **Result:** ___ Neg ___ Pos Induration _____mm **-OR-** Quantiferon Gold (IGRA) **Date**_____ **Result:** ___ Neg ___ Pos	**If positive PPD or prior history of +PPD: Chest x-ray required within last 2 years** **CXR Date**_____ **Results:** ____ Normal ____ Abnormal **Drug** Therapy**:** Drug used_____ **Dates:**_____ **to** _____
PPD given by:	**PPD results read by:**

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

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
Deadlines: August 1 for fall registration | January 1 for spring registration

04/2020 JAL