



Mount Aloysius College Student Health Record

Health Records are kept confidential

Health Services Office

St. Joseph Hall 100A-102

7373 Admiral Peary Highway, Cresson, PA 16630

(814) 886-6515 or (814)886-6391 Fax (814) 886-2978

Make copies for your records

Health Majors will be contacted prior to going into clinical for additional requirements that will need to be submitted to an outside provider. Please make copies so that you have dates and a copy of your physical exam.

Important!

Completion of this form is a pre-entrance requirement for all students. Forms must be completed and turned into Health Services prior to the start of classes.

Deadlines:

August 15th for the Fall Semester

January 1st for the Spring Semester

MENINGITIS ON CAMPUS

Know Your Risk

Learn About Vaccination

Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, freshmen living in dorms are found to have a six-fold increased risk for the disease. A U.S. health advisory panel recommends that college students, particularly freshmen living in dorms, learn more about meningitis and vaccination.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States – types A, C, Y and W-135. Protective antibody levels may be achieved within 7-10 days after vaccination and provides protection for approximately 3 to 5 years. As with any vaccine, it may not protect 100% of all susceptible individuals.

Senate Bill 955 states that colleges shall prohibit a student from residing in a dormitory unless the student has received a one-time vaccination against meningococcal disease. A student is exempt if they sign a written waiver stating that they have received and reviewed information provided by the college and have chosen not to be vaccinated.

- ❖ What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.
- ❖ How is it spread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
- ❖ What are the symptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
- ❖ Who is at risk? Certain college students, particularly freshmen who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

For more information: To learn more about meningitis and the vaccine visit Mount Aloysius College Health Services Office. You can also visit the websites of the Center for Disease Control and Prevention (CDC) at www.cdc.gov/ncidod/dbmd/diseaseinfo and the American College Health Association at www.acha.org. The vaccine is available to all students through Health Services. Please visit (St. Joe's Hall Room 100-102) or call (814-886-6515) to make an appointment. Waiver forms are also available in Health Services, but we strongly urge you to receive the vaccine if you haven't done so already.



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To be completed by the student.
Parent/guardian must sign if student is under 18 years of age.

Major _____ Year: _____ Date of Admission _____ (M/Y) Student ID # _____

Please Notify Health Services immediately of any name and address changes.

Student's Last Name		First Name		MI	Maiden	Date of Birth	
Home Address					Citizen of USA yes or no		If no, Citizen of what Country
City		State	Zip	(Area Code) Home phone	(Area Code) Cell Phone	(Area Code) Work Phone	
Age	Sex	Email:			Living on the college campus as a resident. yes or no		Commuter yes or no
Participation in Intercollegiate Athletics		Yes	No	Sport			

Emergency Contact
(All students must list an emergency contact)

Name _____

Address _____

Relationship _____

Home Phone _____

Work Phone _____

Cell Phone _____

Allergies

_____ No Known Allergies

Allergic to:	Reactions

Health Insurance Information

Insurance Co. Name:	Subscriber's Name	ID or Policy #	Group #
Insurance Co Address:			

Health Insurance is REQUIRED for Resident Students living on campus and Intercollegiate Athletes!

*****Please Attach A Copy of Your Insurance Card. Front and Back*****

Health Care Provider (Family Physician)

Name				
Address		City	State	Zip
Phone		Fax		

Personal History: Please comment on all yes answers in comment section or on an additional sheet.

Have You Had?	Y	N		Y	N		Y	N		Y	N
Allergies, seasonal			Diarrhea, Frequent			HIV/AIDS			Strep throat, recurrent		
Anemia			Dizziness, Fainting			Insomnia			Surgery		
Arthritis			Ear, nose, throat disorder			Kidney disorder			Appendectomy		
Asthma, chronic			Epilepsy			Menstrual Problems			Tonsillectomy		
Asthma, exercise induced			Eye Problem			Mononucleosis			Thyroid Disorder		
Back Problem			Gallbladder Disease			Paralysis			Tuberculosis		
Bronchitis, recurrent			Head Injury			Pneumonia			Tumor/Cyst		
Cancer			Headache, recurrent			Rheumatic Fever			Urinary tract infection		
Chickenpox			Heart condition/Murmur			Sexually transmitted disease					
Counseling			Hepatitis			Sinus Condition					
Depression			Hernia			Stomach Disorder					
Diabetes			High Blood Pressure								

Comments: _____

Have you ever been hospitalized for an illness or injury?

Date _____ Reason for Hospitalization _____

Do you have any chronic health problems which require regular treatment? (If yes, please have your physician write a medical summary and attach it to this form)

Do you take medications? No _____ Yes _____

Medications	Dosage	Frequency	Condition

Social History: Do You?

Smoke pipe, cigar, and cigarettes? No _____ Yes _____ # of packs per day _____ Chew smokeless tobacco? Yes _____ No _____ Would you be interested in a smoking cessation program? Yes _____ No _____ History of addiction: alcohol Yes _____ No _____ other drugs Yes _____ No _____

Consent: I certify that this information is true and complete to the best of my knowledge. I will notify Mt. Aloysius Health Services of any changes in health information. I hereby give permission to Mt. Aloysius Health Services to provide treatment of minor illnesses and injuries, administer prescribed medications, and seek affiliate agencies for clinical practicum, fieldwork and internships. In the event of a medical emergency all of my medical and insurance information will be disclosed to ambulance personnel and the admitting hospital and my emergency contact will be notified unless otherwise stated.

X _____ Signature of Student: Date: _____

X _____ Signature of Parent/guardian if under 18: Date: _____



Student Physical Exam (FRONT and BACK)

Must be completed and signed by a Health-Care Provider (Family Physician)

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Name: _____

Last		First		Middle Initial	Maiden
Allergies					
Height Feet _____ Inches _____	Weight LBS _____	Blood Pressure	Hearing Normal _____ Abnormal _____ Explain: _____	Vision: Normal _____ Glasses _____ Contacts _____	
Pulse: _____					
Dental Health or Problems: _____					

Clinical Evaluation			Remarks or Additional Information
Check each item in appropriate column, at right.	Normal	Abnormal	
1. Skull, Scalp, Face, Neck,			
2. Nose and Sinuses			
3. Mouth (tongue, gingiva, teeth)			
4. Throat and Tonsils			
5. Thyroid			
6. Ears (Int. and Ext. Canals)			
7. Eyes (Pupils, conjunctiva)			
8. Lungs and chest (Include Breast)			
9. Abdomen and viscera (include hernia)			
10. Gastrointestinal			
11. Endocrine System			
12. Genitourinary System			
13. Musculoskeletal			
14. Feet (flat, pain, infection)			
15. Skin			
16. Lymphatic Glands			
17. Neuropsychiatric			

Do you have any recommendations regarding the care of this student? Yes___ No___

If yes
explain _____

Is the student now under treatment for any medical or emotional condition? Yes___ No___

Explain _____

Recommendations for physical activity in, Intramurals or Intercollegiate Sports:

_____ Unlimited physical activity and able to participate in sports. I certify that I have examined this student and find him/her physically able to participate in intercollegiate athletics.

_____ Limited Physical Activities. Explain _____

_____ No Physical activities. Explain: _____

Signature of Licensed Health-Care Practitioner:

Physician Signature _____
Provider Name, Address, Phone: (Print or Stamp)

Date of exam:

Mount Aloysius College Student Immunization Record

Student's First Name _____ Middle _____ Last Name _____

***REQUIRED OF ALL STUDENTS.**

1. **MMR (Measles/Mumps/Rubella):** (Two doses required. Exempt if born before 1957.) If unable to submit dates antibody IgG blood titers must be submitted indicating immunity, and a copy of the lab report must be attached.
Dose 1 _____ Dose 2 _____ or Date of titers _____ (Attach copy of lab report.)
If titers are not immune please submit the date/s of a booster/s given. _____.

2. **Meningococcal Vaccine:**

RESIDENT STUDENTS: ** REQUIRED by Pennsylvania Law for ALL students living in residence halls.

Date _____ within the last 5 years, or signed waiver (See Vaccine Information and Waiver Record)

Meningitis Waiver:

_____ I have received and reviewed information on the risks associated with meningococcal disease and the availability and effectiveness of the meningococcal vaccine. I have chosen NOT to be vaccinated against meningococcal disease at this time.

3. **Polio:** (Dates)
Completed primary series Yes _____ No _____
Date of Last Booster _____ Please indicate if type OPV (oral) ___ or IVP (inject able) ___
4. **Tetanus Diphtheria: (Within past Ten (10) years).**
Date: _____ Check one _____ TD _____ TDaP _____
5. **Varicella/Chickenpox:** Dose 1 _____ Dose 2 _____, or Date of Disease: _____

Recommended Immunizations

- **Hepatitis B**
1 _____ 2 _____ 3 _____
- **PPD (Tuberculin Purified Protein Derivative) Mantoux Testing**

Are you a High Risk Student? Yes ___ NO ___ (See statement below for definition of High Risk)

TB screening is required of all students at high risk for TB as defined by the CDC (foreign persons from high prevalence countries, persons with compromised immune systems, close contacts of infectious TB cases.) If you answered yes you are considered a high risk student and you are required to receive a PPD. All other student who are not high risk, a PPD is recommended but not required.

Date: _____ Results: _____

If positive, was chest x-ray taken? Date _____ Results _____ (Submit a copy of the Chest X-Ray report)

Have you ever been vaccinated with BCG? Yes ___ No ___ If yes date _____

Request for Exemption from Immunization

A student may be granted medical exemption from immunization based on a written statement from a physician or his designee, that the immunization may be detrimental to the health of the student. A religious exemption from may be granted based on a student's written objection to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief. However, if an outbreak of illness occurs, students who do not provide immunity to these diseases may be excluded from classes. By signing a waiver I cannot hold Mount Aloysius College responsible if I am exposed to any communicable diseases. I choose not to receive the following vaccine(s): Please check all that apply if you do not want this vaccination. **ATTACH WRITTEN DOCUMENTATION AS TO WHY YOU ARE NOT RECEIVING THIS VACCINATION AS STATED ABOVE.**

____ MMR (Measles, Mumps, and Rubella) ____ Tetanus-Diphtheria ____ Varicella (Chicken Pox) ____ Polio

Student Signature/Parent Signature

Date

Physician Signature

Date

Signature of Licensed Health-Care Practitioner:

Verification: I have reviewed the student's health information, examined the student and certify there is no medical evidence, which would preclude the student's participation in college.

Physician Signature _____

Provider Name, Address, Phone: (Print or Stamp)

Date: