



## 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*

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*(814) 886-6515 or (814)886-6391 Fax (814) 886-6575*

***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 15<sup>th</sup> for the Fall Semester**

**January 1<sup>st</sup> for the Spring Semester**



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**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.

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 \_\_\_\_\_

### 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
Phone		Fax	

**Family Medical History ( Please check any significant medical history that pertains to your immediate family (Mother, Father or Siblings)**

	Yes	No		Yes	No
Allergies			Seizures		
Mental/Nervous Disease			Tuberculosis		
Diabetes			Migraine Headaches		
Heart Trouble					

**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: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Special Needs –Dietary, Housing, Support Services to facilitate Learning: \_\_\_\_\_  
 \_\_\_\_\_

Do you take medications ? No \_\_\_\_\_ Yes \_\_\_\_\_

Medications	Dosage	Frequency	Condition

**Social History: Do You?**

Smoke pipe, cigar, 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 ____
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**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**

**Must be completed and signed by a Health-Care Provider**

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**Make copies for your records**

**Name:** \_\_\_\_\_

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

<b>Clinical Evaluation</b>				<b>Remarks or Additional Information</b>
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: \_\_\_\_\_

**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 or participation at the clinical site.

**Signature of Licensed Health-Care Practitioner:**

**X** \_\_\_\_\_ **Print Name or Name of Practice** \_\_\_\_\_ **Date** \_\_\_\_\_

**Street Address** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_ **Phone** \_\_\_\_\_

# 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 Pertussis (TDaP): (Within past Ten (10) years).**  
Date: \_\_\_\_\_
5. **Varicella/Chickenpox:** Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_, or Date of Disease: \_\_\_\_\_

## **Recommended Immunizations**

- **Hepatitis B**  
1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_
- **PPD (Tuberculin Purified Protein Derivative) Mantoux Testin**

**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

\_\_\_\_\_  
Health Care Practitioner's 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.

**Health Care Practitioner's Signature:**

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

**Date:**



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## 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.

CDC has new recommendations as of 1-1-2011. CDC is now recommending that students have a Meningitis vaccine on or after age 16 (regardless if or when previous Meningitis vaccines were administered). For optimal protection, a 2nd vaccination is recommended within a five year period for college students living in residential halls.

**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 and 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](http://www.cdc.gov/ncidod/dbmd/diseaseinfo) and the American College Health Association at [www.acha.org](http://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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## **MENINGOCOCCAL VACCINE WAIVER FORM**

**\*\*Must be completed by all dormitory students\*\***

According to the Pennsylvania College and University Vaccination Act of July 2002 (Senate Bill 955), students who reside in a dormitory must receive a vaccination against meningococcal disease. A student is exempt from the vaccination requirement if the college provides detailed information on the risks associated with meningococcal disease, the availability and effectiveness of the vaccine and the student signs a written waiver. If the student is a minor, the student's parent or guardian must sign the waiver.

### **PLEASE CHECK ONLY ONE OPTION**

- I have received the meningitis vaccine on \_\_\_\_\_ (mm/dd/yy)
- I have received and reviewed information on the risks associated with meningococcal disease and the availability and effectiveness of the meningococcal vaccine. I chose NOT to be vaccinated against meningococcal disease at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at Health Services or elsewhere.

**Print Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**If student is 18 years of age or older**

Signature of Resident Student: \_\_\_\_\_

**If student is under 18 years of age**

Signature of Parent/Guardian: \_\_\_\_\_

**PLEASE COMPLETE AND RETURN TO HEALTH SERVICES PRIOR TO MOVING INTO THE DORMITORY!**



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## Annual Pre-Participation Athletic Medical History

Name: \_\_\_\_\_ Sport: \_\_\_\_\_

Chronic Illnesses: \_\_\_\_\_

Recent Acute Illnesses: \_\_\_\_\_

Past Hospitalizations: \_\_\_\_\_

Past Surgeries: \_\_\_\_\_

Past Injuries: \_\_\_\_\_

Allergies: \_\_\_\_\_

(Drug, Food, Environmental)

Medications: \_\_\_\_\_

(Over the counter, Prescription, Vitamins)

Prior limitations placed on sports participation: \_\_\_\_\_

### THE NEXT 2 APPLY TO FEMALE ATHLETES ONLY:

Pregnancies: \_\_\_\_\_

Menstrual History: \_\_\_\_\_

(Age of menses, duration, frequency)

### Check all that apply (Male and Female athletes):

- Previous concussion or loss of consciousness
- Syncope or near syncope with exercise
- Symptoms of exercise-induced bronchospasm
- Loss of paired organ function (eye, kidney, lung, testicle)
- Excessive fatigue
- Exertion chest pain
- Excessive exertion shortness of breath
- History of heat related illness
- History of cardiac disease or symptoms
- History of heart murmur
- History of high blood pressure
- Possible exposure to Tuberculosis (TB)
- Family history of sudden death (under age 50 from non-traumatic cause)
- Family history of heart disease
- Family history of Marfan syndrome

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## Reminder

- Don't forget! Athletes must have a copy of their health insurance on file in Health Services. Health Insurance is a requirement for all athletes.
- First year athletes must receive their initial physical from a health care practitioner.
- If athletes are living on campus you must have received the meningitis vaccine or sign the waiver.
- All health information must be complete and submitted to Health Services before the beginning of classes. You will not be able to participate in your sport until all information is completed.

Thank You