

# Confidential Health Record

**\*\*FOR STUDENT TO COMPLETE\*\***

LEGAL NAME \_\_\_\_\_ D.O.B. \_\_\_\_\_ CELL # \_\_\_\_\_

PREFERRED NAME \_\_\_\_\_ PREFERRED PRONOUNS \_\_\_\_\_ SEX \_\_\_\_\_ GENDER IDENTITY \_\_\_\_\_

PERMANENT HOME ADDRESS \_\_\_\_\_  
(Street) (City) (State) (Zip)

IN CASE OF EMERGENCY NOTIFY \_\_\_\_\_  
(Name) (Phone) (Relationship)

FAMILY PHYSICIAN \_\_\_\_\_  
(Name) (Address) (Phone)

**ALLERGIES/SENSITIVITIES (include reaction):**

- 01  Macrolides \_\_\_\_\_
- 02  Penicillin \_\_\_\_\_
- 03  Sulfa \_\_\_\_\_
- 04  Pollen \_\_\_\_\_
- 05  Insect \_\_\_\_\_
- 06  Animal \_\_\_\_\_
- 07  Food \_\_\_\_\_
- 08  **None known** \_\_\_\_\_
- 09  Other (please specify) \_\_\_\_\_

**PRESENT MEDICATIONS (include dosage):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY MEDICAL HISTORY**

- 01  Alcoholism
- 02  Anemia
- 03  Bleeding tendency
- 04  Cancer
- 05  Diabetes
- 06  Heart disease
- 07  Hereditary disease
- 08  High Blood Pressure
- 09  Mental Illness
- 10  Migraine
- 11  Obesity
- 12  Sudden death
- 13  Stroke
- 14  Tuberculosis
- 15  **None known**
- 16  Other (please specify) \_\_\_\_\_

**HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?**

- 01  Anxiety
- 02  Anemia
- 03  Anorexia Nervosa
- 04  Asthma
- 05  Frequent UTI
- 06  Bleeding tendency
- 07  Bulimia
- 08  Cancer or malignancy
- 09  Chicken Pox
- 10  Irritable Bowel Syndrome
- 11  Crohn's disease
- 12  Diabetes
- 13  Depression
- 14  Drug, Alcohol Abuse/Addiction
- 15  Head Injury/Concussion
- 16  Hypertension
- 17  Infectious Mononucleosis (Mono)
- 18  Kidney stones
- 19  Major Joint Injury
- 20  Menstrual Disorders
- 21  Obesity
- 22  Passing out
- 23  Pelvic Infection
- 24  Peptic ulcer
- 25  Phlebitis
- 26  Rheumatoid Arthritis
- 27  Seizure Disorders
- 28  Self Harm
- 29  Suicide Ideation
- 30  Thyroid Disease
- 31  Tuberculosis or ⊕ TB test
- 32  Ulcerative Colitis
- 33  Sexually Transmitted Diseases
- 34  Hepatitis
- 35  **None of the above**
- 36  Other (please specify) \_\_\_\_\_
- 37  Please explain check marks \_\_\_\_\_

**PLEASE CHECK ANY OF THE FOLLOWING IF THEY APPLY:**

**HEART CONDITION**

- 01  Congenital
- 02  Murmur, uncertain cause
- 03  Mitral Valve Prolapse
- 04  Rheumatic Heart Disease
- 05  Valvular Heart Disease
- 06  Other (please specify) \_\_\_\_\_

**DO YOU NOW HAVE OR ARE YOU UNDER TREATMENT FOR ANY OF THE FOLLOWING PROBLEMS?**

- 01  Acne (under treatment)
- 02  Acquired Immune Deficiency Syndrome
- 03  ADD/ ADHD
- 04  Ankylosing Spondylitis
- 05  Anxiety
- 06  Binge Eating
- 07  Bipolar/Mood disorder
- 08  Blood Disorders
- 09  Cerebral Palsy
- 10  Chronic Bronchitis
- 11  Chronic kidney condition
- 12  Chronic inflammatory bowel disease
- 13  Condyloma (genital warts)
- 14  Depression
- 15  Diabetes Mellitus
- 16  Digestive troubles
- 17  Dizziness/fainting
- 18  Dysmenorrhea (severe menstrual cramps)
- 19  Hayfever
- 20  High Blood Pressure
- 21  Insomnia
- 22  Migraine
- 23  Multiple Sclerosis
- 24  Muscular Dystrophy
- 25  Obesity
- 26  Psoriasis
- 27  Recurrent diarrhea
- 28  Reiter's Syndrome
- 29  Recurrent headaches
- 30  Rheumatoid Arthritis
- 31  Systemic Lupus Erythematosus
- 32  Tuberculosis or ⊕ TB test
- 33  Laxative use for weight loss
- 34  Vomiting for weight loss
- 35  **None of the above**
- 36  Other (please specify) \_\_\_\_\_

**LIST CONSULTANTS AND SPECIALISTS SEEN RECENTLY OR ON A REGULAR BASIS:** \_\_\_\_\_

**PLEASE LIST ANY SPECIAL NEEDS (DIET, TREATMENTS, ETC):** \_\_\_\_\_

# REPORT OF MEDICAL EXAMINATION

**\*\*FOR PHYSICIAN TO COMPLETE\*\***

**TO THE EXAMINING PHYSICIAN:** This student has been accepted. Please review the student's history and complete this examination with comments on any diseases or defects. **PLEASE BE AS THOROUGH AS POSSIBLE**

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

DISTANT VISION (*do both if correction required*)

Uncorrected Right 20/ \_\_\_\_\_ Corrected to 20/ \_\_\_\_\_  
Uncorrected Left 20/ \_\_\_\_\_ Corrected to 20/ \_\_\_\_\_

Does the individual wear Corrective lenses?  Glasses  Contacts

GROSS HEARING \_\_\_\_\_

## CLINICAL EVALUATION

	Normal	Abnormal	Not Examined	Describe details of abnormalities of number
1. Head and Scalp				
2. Nose and Throat				
3. Mouth and Dentition				
4. Ears				
5. Eyes				
6. Lungs and Chest				
7. Heart				
8. Vascular system				
9. Abdomen				
10. Genitourinary				
11. Endocrine, Metabolic System				
12. Musculoskeletal System				
13. Skin				
14. Neurological System				
15. Psychiatric				

1. Is there known loss or seriously impaired function of ANY ORGAN?  Yes  No

2. Should this individual **be restricted** from participating in: Physical education activity classes?  Yes  No

Intramural/Athletic club activity?  Yes  No

Intercollegiate sports?  Yes  No

\*If physical education activities must be restricted please specify the type of activities and specific limitations.  
(Please attach your details on your letterhead about activities.)

3. General comments or recommendations: \_\_\_\_\_

4. Is this individual currently under care for a chronic condition or serious illness?  Yes  No If yes, please list: \_\_\_\_\_

5. Will this individual be taking medication on a regular basis?  Yes  No If yes, please list: \_\_\_\_\_

6. Please confirm psychiatric status with diagnoses and medications if applicable: \_\_\_\_\_

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Print Name \_\_\_\_\_ Telephone Number \_\_\_\_\_

Address \_\_\_\_\_

# IMMUNIZATION RECORD

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. ALL INFORMATION MUST BE IN ENGLISH.**

**THE FOLLOWING ARE MANDATORY FOR ADMISSION:**

***IF YOU ARE ATTACHING RECORDS PLEASE MAKE SURE THEY FIT THE REQUIREMENTS BELOW!***

**A. TETANUS-DIPHTHERIA-PERTUSSIS (DTaP/TdaP) OR TETANUS-DIPHTHERIA (dT) (CIRCLE ONE)**

Within the last 10 years .....        /        /         
Mo Yr

**B. M.M.R. (MEASLES, MUMPS, RUBELLA) (two doses required)**

1. Dose 1 given at age 12-15 months or later..... #1        /         
Mo Yr

2. Dose 2 given at age 4-6 years or later, and at least one month after first dose..... #2        /         
Mo Yr

**C. POLIO**

1. Completed primary series of polio immunization: Yes \_\_\_\_\_ No \_\_\_\_\_ Date of last booster:.....        /        /         
Mo Yr

**D. VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized at the age of 13 or older meets the requirement)**

1. History of disease Yes \_\_\_\_\_ No \_\_\_\_\_

2. Varicella antibody        /        Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_  
Mo Yr

3. Immunization

a. Dose #1..... #1        /         
Mo Yr

b. Dose #2 given at least one month after first dose, if age 13 years or older..... #2        /         
Mo Yr

**E. TUBERCULOSIS SCREENING (PLEASE DO NOT SKIP SCREENING QUESTIONS!)**

1. Does the student have signs or symptoms of active tuberculosis disease? Yes \_\_\_\_\_ No \_\_\_\_\_

**If No**, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group or is the student entering the health professions? Yes \_\_\_\_\_ No \_\_\_\_\_

**If No**, STOP. If Yes, place tuberculin skin test (Mantoux only; Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally onto the surface of the forearm OR do blood test (see #5).  
A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test:

Date Given:        /        /        Date Read:        /        /         
Mo Day Yr Mo Day Yr

Result: \_\_\_\_\_ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): Positive \_\_\_\_\_ Negative \_\_\_\_\_

4. Chest x-ray (required if tuberculin skin test is positive) result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Date of chest x-ray:        /        /         
Mo Day Yr

5. QuantiFERON Gold blood test results: \_\_\_\_\_

**F. HEPATITIS B (at least one of the following):**

1. Immunization (Hepatitis B)

a. Dose #1        /        b. Dose #2        /        c. Dose #3        /         
Mo Yr Mo Yr Mo Yr

2. Immunization (combined Hepatitis A and B Vaccine)

a. Dose #1        /        b. Dose #2        /        c. Dose #3        /         
Mo Yr Mo Yr Mo Yr

3. Hepatitis B surface antibody Date        /        /        Result: Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_  
Mo Yr

**G. MENINGOCOCCAL MENINGITIS (GROUP A) (Must have one dose AFTER age 16)**

1. Date \_\_\_\_/\_\_\_\_/\_\_\_\_ 2. Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr Mo Yr

**H. FOR STUDENT ATHLETES ONLY: SICKLE CELL SCREENING**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_  
Mo Yr

**THE FOLLOWING ARE OPTIONAL BUT HIGHLY RECOMMENDED**

**I. HEPATITIS A**

1. Immunization (Hepatitis A)

a. Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ b. Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr Mo Yr

**J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE (for members of high-risk group)**

Pnevnar 13® Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Pneumovax® Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr Mo Yr

**K. INFLUENZA\* (Annual immunization recommended for everyone)**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr

\*THIS VACCINE WILL BE OFFERED DURING THE FALL AT A NOMINAL FEE

**L. QUADRIVALENT HUMAN PAPILOMAVIRUS VACCINE (HPV):**

(Three doses of vaccine recommended for all college students 11-26 years of age at 0, 2, and 6 month intervals.)

a. Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ b. Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ c. Dose #3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr Mo Yr Mo Yr

**M. MENINGOCOCCAL (GROUP B)**

Bexsero®: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ OR Trumenba®: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Yr Mo Yr Mo Yr Mo Yr Mo Yr

**Health Care Provider**

Signature \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax: \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

E-mail: \_\_\_\_\_

*If there are any questions or concerns, please contact Paul P. Doghramji, MD, UC Medical Director,  
or the Wellness Center Office Manager at wellness@ursinus.edu.*

**RETURN TO:** Ursinus College Wellness Center  
**NO LATER THAN:** July 30<sup>th</sup> for Fall Registration & January 30<sup>th</sup> for Spring Registration

URSINUS COLLEGE WELLNESS CENTER  
601 E. Main St. Collegeville, PA 19426  
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