

Confidential Health Record

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

LEGAL NAME _____ D.O.B. _____ SEX _____ CELL # _____

PREFERRED NAME _____ PREFERRED PRONOUNS _____ 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 Covid-19
- 21 Menstrual Disorders
- 22 Obesity
- 23 Passing out
- 24 Pelvic Infection
- 25 Peptic ulcer
- 26 Phlebitis
- 27 Rheumatoid Arthritis
- 28 Seizure Disorders
- 29 Self Harm
- 30 Suicide Ideation
- 31 Thyroid Disease
- 32 Tuberculosis or ⊕ TB test
- 33 Ulcerative Colitis
- 34 Sexually Transmitted Diseases
- 35 Hepatitis
- 36 **None of the above**
- 37 Other (please specify) _____
- 38 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 NOW 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 #1 _____ / _____
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:..... #1 _____ / _____
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. COVID-19

J & J®: Dose #1 ___/___/___ OR Moderna®: Dose #1 ___/___/___ Dose #2 ___/___/___
Mo Day Yr Mo Day Yr Mo Day Yr
OR Pfizer®: Dose #1 ___/___/___ Dose #2 ___/___/___
Mo Day Yr Mo Day Yr

Other: _____

I. FOR STUDENT ATHLETES ONLY: SICKLE CELL SCREENING

Date ___/___/___ Result: _____
Mo Yr

THE FOLLOWING ARE OPTIONAL, BUT HIGHLY RECOMMENDED:

J. HEPATITIS A

1. Immunization (Hepatitis A)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___
Mo Yr Mo Yr

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

Prevnar 13® Date ___/___/___ Pneumovax® Date ___/___/___
Mo Yr Mo Yr

L. INFLUENZA* (Annual immunization recommended for everyone)

Date ___/___/___
Mo Yr

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

M. QUADRIVALENT HUMAN PAPILLOMAVIRUS 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

N. 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 Coordinator at wellness@ursinus.edu.

RETURN TO: Ursinus College Wellness Center
NO LATER THAN: July 30th for Fall Registration & January 30th for Spring Registration

URSINUS COLLEGE WELLNESS CENTER
601 E. Main St. Collegeville, PA 19426
PH: 610-409-3100 FAX: 610-409-3778