Student Health Services

Health History Form

The purpose of the health information we require is to assist our health-care providers in giving you the most appropriate care while you are at The University of Scranton. In addition, it helps to ensure that you are properly immunized, reducing the risk to you and to our campus community of infection from vaccine-preventable illnesses.

If you are a transfer student who has a recent physical on file at your former institution, a copy of that will be acceptable. Please complete the Authorization for Release of Confidential Information, sign it and send it to your former student health center for release of the appropriate information.

If you are a Freshman, or transfer student who does not have a recent physical on file at your former institution, please complete the two-page Health History form before you see your health-care provider (physician or nurse practitioner). He/she should complete the Physical Examination form, review and update immunizations, and complete and sign the Immunization Record form. An information sheet listing immunization requirements and recommendations has been included for reference by you and your health-care provider.

Please return completed forms in the envelope that came with your Forms Forms Forms letter to Student Health Services by January 22, OR forward the Authorization for Release of Confidential Information to your previous institution.

Confidentiality of Health Information

Student Health Services at The University of Scranton is committed to protecting the confidentiality of your health information. Health information is used to provide quality medical treatment to you and to comply with certain legal requirements. No information will be released to anyone, within or outside the University community, without the express (usually written) consent of the student. Exceptions include emergency situations or in response to court or administrative order.

Health Insurance Information

All the health services offered on campus are covered by University fees. Student Health Services does no third-party billing. However, care by community providers such as laboratory, X-ray, private physicians or specialists in the community, hospital emergency department visits or hospital admission are subject to insurance coverage or private payment. **All students must be covered by adequate health insurance. Please make a photocopy of your health insurance membership information and attach it to your Health History Form, which is due by January 22.** It is important that you understand how your insurance coverage protects you while you are away at college, how to access that coverage and if there are any restrictions that apply to any type of care.

Alternative Insurance Coverage

Information regarding an alternative insurance plan available for students who do not have insurance coverage or coverage that is inadequate to meet your needs while away from home at college will be provided at your request. We urge you to carefully review your present coverage as well as the information regarding this alternative plan. Expenses associated with unexpected serious illness or injury can have great impact on college financial plans if health insurance coverage is absent or inadequate.

Immunization Requirements and Recommendations

MMR (Measles, Mumps, Rubella)

Two doses of MMR are required. The first dose should have been administered at age 12 to 15 months of age or later, and the second dose at age 4 to 6 years or later. This is required of all entering college students born after 1956. If measles, mumps and rubella vaccines were given separately at age 12 to 15 months, a second dose of measles vaccine is required at age 4 to 6 years or later.
Major Precautions: Pregnancy, history of anaphylactic reaction to eggs or neomycin, or immunosuppression. MMR is appropriate for HIV-antibody-positive persons.

Tetanus-Diphtheria

All entering college students must have received the primary series in childhood with DtaP or DTP (diphtheria, tetanus toxoid, and acellular [whole cell] pertussis), a booster at age 11 to 12 years with Tdap, and then every 10 years.
Major Precautions: History of a neurologic hypersensitivity reaction following a previous dose.

Polio

The primary series must have been completed in childhood with IPV alone, OPV alone, or IPV/OPV sequentially. A booster is needed only for international travel to certain areas after the age of 18.
Major Precautions: OPV should not be given to immunocompromised or HIV-antibody-positive persons.

Varicella (Chicken Pox)

All students who do not have a history of having had the disease or age appropriate immunization should have two doses given at least one month apart, if over the age of 13 years.
Major Precautions: Pregnancy

Hepatitis B

All entering students should have begun the three-dose (dose one, then dose two at 1 to 2 months, and the third at 6 to 12 months) series of Hepatitis B immunization. Completion of the series is required for *all* students enrolled in health-related majors such as nursing, physical therapy and occupational therapy before they go into clinical areas.

Major Precautions: None

Tuberculosis Screening

The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations for the Centers for Disease Control and the American Thoracic Society. For more information, visit **www.acha.org** or refer to the CDC's Core Curriculum on Tuberculosis, available at state health departments or online at **www.cdc.gov/nchstp/tb/pubs/corecurr**.

Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries other than Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, United States, U.S. Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand.

Other categories of high-risk students include:

- those with HIV infection;
- those who inject drugs;
- those who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters;
- those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioleal by-pass, chronic malabsorption syndromes, prolonged corticosteriod therapy (e.g., prednisone ≥ 15 mg/d for ≥ one month), or other immunosuppressive disorders.

If the student is a member of any of the risk groups or is entering the health professions, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing five tuberculin units [TU] intradermally into the volar surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group. Please interpret and record results at 48 to 72 hours after the injection.

Meningococcal Immunization

Pennsylvania law now requires students enrolled in Pennsylvania institutions of higher education (including The University of Scranton) residing in residence halls or other University owned housing be vaccinated against meningococcal disease.

Students who wish to be exempt from this requirement must meet the following conditions: the student (or parent/legal guardian in the case of students under the age of 18 years), after having been advised of the risks of the disease and the availability and effectiveness of the vaccine, must sign a written waiver (to the right) stating that he or she has reviewed the information and has chosen not to be vaccinated against the disease for religious or other reasons.

It is also recommended that other students who wish to reduce their risk consider vaccination.

Overview of Meningococcal Disease and Immunization

What is Meningococcal disease?

Meningococcal disease is a rare but life-threatening infection caused by the bacterial organism *Neisseria meningitidis.* It is most commonly manifested as either meningococcal **meningitis**, an inflammation of the membranes surrounding the brain and spinal cord, or **meningococcemia**, a presence of the bacteria in the blood. Research conducted by the American College Health Association and federal Centers for Disease Control has shown a sixfold increase in risk for this disease in college students during the 1990s, particularly first-year students living in college residence halls. Data suggest that certain social behaviors, such as exposure to passive and active smoking, bar patronage and excessive alcohol consumption, may increase students' risk for contracting the disease.

Is meningitis contagious?

Yes, some forms of bacterial meningitis are contagious. The bacteria are spread through the exchange of respiratory and throat secretions (e.g., coughing, kissing). Fortunately, none of the bacteria that cause meningitis are as contagious as things like the common cold or the flu, and they are not spread by casual contact or by simply breathing the air where a person with meningitis has been.

About Meningococcal vaccines

A meningococcal vaccination (Menomune®) has been used since the 1970s to protect against the most common forms of the bacteria causing up to 83% of the cases in adolescents and young adults (*N. meningiditidis* strains A,C, Y and W-135 but not strain B). Recently a "conjugate" meningoccal vaccine (Menactra®) has been licensed by the FDA for use in the United States. Meningococcal vaccines have been demonstrated to be safe. As with all vaccines, however, some reactions (e.g., soreness or redness at the injection site for one or two days) can happen, and no vaccine is guaranteed to protect 100% of individuals. Persons with known hypersensitivity to any component of the vaccine should not be vaccinated. Persons with acute illness with fever (101° or higher) should delay vaccination.

How can students receive vaccination?

Most students arrange for immunization privately with their family physician or clinic as part of the required preadmission physical examination. Menactra® will be available at Student Health Services for those who are unable to obtain it prior to coming to the University.

In the following section you will find an optional waiver form.

THE UNIVERSITY OF SCRANTON
A JESUIT UNIVERSITY

Student Health Services

Student Health Services, 800 Linden Street, Scranton, PA 18510
Phone: (570) 941-7667 • Fax: (570) 941-4298

Meningococcal Vaccine Pre-Order/Pre-Pay Program

Pre-ordering and pre-paying for the meningococcal vaccine, Menactra® A/C/Y/W-135 Polysaccharide Diphtheria Toxoid Conjugate Vaccine, guarantees you a reserved dose to be given at Student Health Services. **The cost of $100** covers the vaccine and associated administration costs. **Please call Student Health Services as soon as possible after arriving on campus to make an appointment, and mark it on your calendar.**

Method of payment (to "The University of Scranton"): ❑ Check ❑ Money Order

I understand that by pre-ordering and pre-paying for the meningococcal vaccine, a dose will be reserved for me. I also understand that I must make an appointment at Student Health Services to receive the vaccine.

Student's name (Last, First) _____ Royal ID _____

Student's signature _____ Date _____

If student is under 18, parent/guardian's signature _____ Date _____

You can return this form to the address above by January 22.

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Optional Waiver for Meningococcal Immunization

For students 18 years of age or older: I am 18 years of age or older. I have received and reviewed the information provided regarding the risk of meningococcal disease and the effectiveness and availability of a meningococcal vaccine. I understand that meningococcal disease is a rare but life-threatening illness. I understand that Pennsylvania law requires that a student enrolled in an institution of higher education in Pennsylvania who resides in University-owned housing shall receive vaccination against meningococcal disease unless the student signs a waiver to the vaccination.

I choose to waive receipt of meningococcal vaccine for religious or other reasons.

Student's name _____ Royal ID_____

Student's signature _____ Date _____

If student is under 18, parent/guardian's signature _____ Date _____

You can return this form to the address above by January 22.

THE UNIVERSITY OF SCRANTON
A JESUIT UNIVERSITY

Student Health Services

Student Health Services, 800 Linden Street, Scranton, PA 18510-4507
Phone: (570) 941-7667 • Fax: (570) 941-4298

Health History

The primary purpose of this form is to ensure that immunizations are current and to provide a historical basis for the provision of health care through Student Health Services. The information is ***confidential*** and will not be released without the student's consent and will not affect admission status.

Complete this portion before going to your physician for examination. Please print.

Student's name (last, first, middle) _____

Home address _____

City _____ State _____ Zip code _____

Telephone number _____ Student's cell phone number _____

Royal ID _____ Social Security number _____

❑ Female ❑ Male Date of birth _____ Marital status _____ Expected graduation year _____

Residence Plan: ❑ On campus/University housing ❑ Home/Commute ❑ Other _____

Emergency Information

Name _____ Relationship _____

Address _____ Telephone number _____

Accident and/or Health Insurance

Insurance company name _____

Insurance company address _____

Agreement/Policy number (include letters) _____ Group number _____

Name of insured _____ Relationship _____

Family Medical History

Check the appropriate box if any of the following apply to your family.

Disease	*Relationship*
❑ Alcoholism/Drug Addiction	_____
❑ Cancer	_____
❑ Diabetes	_____
❑ Heart Disease	_____
❑ High Blood Pressure	_____
❑ Emotional/Mental Illness	_____
❑ Stroke	_____
❑ Other (specify)	_____

Rev. 1/08 (12681)

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THE UNIVERSITY OF SCRANTON
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Student Health Services

Student's name (last, first, middle) _____

Personal Medical History

Have you ***ever had*** any of the following medical problems?

- ❑ Anemia
- ❑ Anorexia Nervosa
- ❑ Asthma
- ❑ Bleeding Trait
- ❑ Bulimia
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Chronic Inflammatory Bowel Disease
- ❑ Diabetes
- ❑ Emotional/Mental Illness
- ❑ Fractures (type: _____)
- ❑ German Measles (Rubella)
- ❑ Head Injury or Concussion
- ❑ Hepatitis (type: _____)
- ❑ Hypertension (high blood pressure)
- ❑ Joint/Muscle/Tendon Problem (type: _____)
- ❑ Kidney Stones
- ❑ Measles (Rubeola)
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Obesity
- ❑ Pelvic Infection
- ❑ Peptic Ulcer
- ❑ Phlebitis
- ❑ Polio
- ❑ Prostatitis
- ❑ Rheumatic Fever
- ❑ Seizure Disorder (Epilepsy)
- ❑ Sexually Transmitted Disease
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Urinary Tract Infection
- ❑ Other (specify): _____

Are you being treated for ***any*** medical condition? ❑ Yes ❑ No
Please specify: _____

Are you taking any medication? ❑ Yes ❑ No
Please specify: _____

Do you have now, or have you ever been told, that you have a heart condition? ❑ Yes ❑ No
Please specify: _____

Have you ever taken any supplements or vitamins in an effort to gain or lose weight or improve your performance? Please specify: ❑ Yes ❑ No
_____

Have you ever experienced chest pain, dizziness or loss of consciousness during or after exercise? ❑ Yes ❑ No
Please specify: _____

Has anyone in your family experienced a sudden, serious cardiac event before the age of 40? ❑ Yes ❑ No
Please specify: _____

Allergies

Are you allergic to ***anything*** – including prescription medications, over-the-counter medications, foods, insects, inhalants? Please specify allergy and reaction.

❑ No known allergies

Allergic to: _____

_____

Reaction: _____

_____

Women Only

- ❑ Excessive Flow
- ❑ Pregnancy
- ❑ Amenorrhea (no periods) – number of months: _____
- ❑ Irregular Periods
- ❑ Discharge from breast
- ❑ Severe Cramps
- ❑ Other (specify): _____

Student's signature _____ **Date** _____

Please return this form to the address above by January 22.

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Student Health Services

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Physical Examination

This section is to be completed by the physician/clinician. Please print.

Student's name (last, first, middle) _____

Blood Pressure _____ / _____ Pulse _____ Height _____ Weight _____

Visual Acuity (R) 20/ _____ (L) 20/_____

Systems Review

	Normal	*Abnormal*	*Describe Abnormalities*
Skin	_____	_____	_____
HEENT	_____	_____	_____
Lymph Nodes	_____	_____	_____
Neck	_____	_____	_____
Heart	_____	_____	_____
Lungs	_____	_____	_____
Back	_____	_____	_____
Breasts	_____	_____	_____
Abdomen	_____	_____	_____
Genitalia (Male)	_____	_____	_____
Pelvic (Female)	_____	_____	_____
Rectal	_____	_____	_____
Musculoskeletal	_____	_____	_____
Neuro/Psych	_____	_____	_____

General Comments

Recommendations for physical activity (PE, Intramurals, ROTC, Athletics)

Unlimited _____ Limited _____ Explain: _____

_____

Do you have any recommendations regarding the care of this patient? _____

_____

Is this patient now under treatment for any medical or emotional condition? _____

_____

Physician's Information

Physician's Name _____ Telephone number (_____)_____

Address_____

Physician's Signature _____ Date_____

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THE UNIVERSITY OF SCRANTON
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Reviewed by_____
(Student Health Services staff)
Date_____

Student Health Services

Student Health Services, 800 Linden Street, Scranton, PA 18510
Phone: (570) 941-7667 • Fax: (570) 941-4298

Immunization Record

To be completed and signed by health-care provider. Dates must include month and year.

Student's name (last, first, middle) _____

Date of birth (month, day, year) _____ Royal ID _____

A. **M.M.R.** (Measles, Mumps, Rubella) Two doses required.
1. Dose 1 given at age 12 to 15 months or later .....____/____
2. Dose 2 given at age 4 to 6 years or later, and at least 1 month after first dose.....____/____

B. **Tetanus-diphtheria** (Primary series with DtaP or DTP and booster with Tdap in the last 10 years)
1. Completed primary series of four doses with DtaP or DTP.....____/____
2. Tetanus-Diphtheria (Td) booster within the last 10 years .....____/____
3. Tetanus toxoid, diphtheria and acellular pertussis (Tdap) *(preferred)*.....____/____

C. **Polio**
Completed primary series of polio immunization ❑ Yes ❑ No
Type of vaccine: ❑ OPV (Sabin, 3 doses) ❑ IPV (Salk – 4 doses) ❑ IPV/OPV sequential
Date of last booster .....____/____

D. **Varicella** (Two doses of vaccine given at least one month apart if immunized after age 13)
1. Dose 1 .....____/____ 2. Dose 2.....____/____

E. **Hepatitis B** (Three doses of vaccine or a positive Hepatitis surface antibody)
1. Dose 1 .....____/____ 2. Dose 2 .....____/____ 3. Dose 3 .....____/____

F. **Meningococcal** Meningitis A, C, Y, W-135 (One dose – required by Pennsylvania law for all college students living in residence halls and to be considered by any student who wishes to reduce the risk of disease.)
❑ Menomune® ❑ Menactra® .....____/____

G. **Quadrivalent Human Papillomavirus Vaccine**
1. Dose 1 .....____/____ 2. Dose 2 .....____/____ 3. Dose 3 .....____/____

H. **Tuberculosis Screening (THIS SECTION MUST BE COMPLETED)**
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? ❑ Yes ❑ No
If No, stop. If Yes, proceed with tuberculin skin testing (Mantoux).
A history of BCG vaccination should not preclude testing of a member of a high-risk group.

3. Tuberculin Skin Test (Mantoux only within past year)
Date Given (month, day, year): ____/____/____ Date Read (month, day, year): ____/____/____
Result: _____ (Record actual mm of induration; if no induration, write "0")

4. Chest X-ray (required if tuberculin skin test is positive)
Results: ❑ Normal ❑ Abnormal Treatment: _____

Health Care Provider's Signature_____

Address_____ Telephone number _____

Please return this form to the address above by January 22.