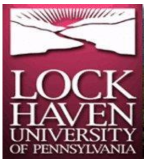

Glennon Student Health Services
Student Medical Form

ALL STUDENTS!
RETURN THIS FORM TO:
LOCK HAVEN UNIVERSITY
GLENNON HEALTH SERVICES
401 NORTH FAIRVIEW ST.
LOCK HAVEN, PA 17745
PHONE: 570.484.2276
FAX: 570.484.2522

- **KEEP A COPY** OF THIS FORM, AND ANY ATTACHMENTS, FOR YOUR RECORDS
- SUBMISSION OF THIS **FORM IS MANDATORY FOR ALL LHU STUDENTS**
- **ATHLETES** –TO PARTICIPATE IN A SPORT AT LHU, A **COMPLETED MEDICAL FORM MUST BE SUBMITTED TO GLENNON STUDENT HEALTH SERVICES PRIOR** TO ANY NCAA TRYOUT/PARTICIPATION. A **COPY** SHOULD BE GIVEN TO THE ATHLETIC TRAINER BY STUDENT.

DATE OF ENTRANCE: SUMMER SPRING FALL 20 ___ CLASS STATUS: ___FR___SO___JR___SR___GRAD___TRANSFER		CITIZENSHIP: ☐ US ☐ OTHER	
LAST NAME	FIRST NAME	MI	D.O.B
HOME ADDRESS (STREET & NUMBER)			☐ COMMUTER
CITY		PHONE	
STATE	ZIP	CELL	
EMERGENCY CONTACT NAME		PHONE	
RELATIONSHIP		CELL	
SPORT(S):	☐ MEN ☐ WOMEN	MAJOR ☐ UNDECIDED	ID#

INSURANCE ATTACH COPIES OF **ALL** MEDICAL/DENTAL CARDS (FRONT & BACK) IN THE SECTION BELOW. ATTACH SECONDARY INSURANCES TO NEW PAGE. FAILURE TO SUBMIT INSURANCE INFORMATION WILL RESULT IN LABORATORY/XRAY/HOSPITAL CHARGES BEING BILLED DIRECTLY TO YOU.

FULL NAME OF PERSON THAT CARRIES INSURANCE	D.O.B.	PHONE
HOME ADDRESS (STREET & NUMBER)	CITY/STATE	
RELATIONSHIP TO STUDENT	ZIP	
EMPLOYER		
CONTACT YOUR INSURANCE MEMBER SERVICES ABOUT COVERAGE IN THE LOCK HAVEN, PA AREA **INSURANCE CARD FRONT	**INSURANCE CARD BACK**	

OFFICE USE

LOCAL ADDRESS		LOCAL PHONE
☐ COMMUTER	RECEIVED	CHECKED

FULL NAME	D.O.B.	ID#

PERSONAL HEALTH HISTORY (TO BE COMPLETED & SIGNED BY STUDENT)

MEDICATIONS ☐NONE Prescription, non-prescription, vitamins, herbal, etc.

MEDICATION	DOSE	TIMES PER DAY	MEDICATION	DOSE	TIMES PER DAY

ALLERGIES /REACTIONS ☐ NONE

MEDICINE/FOOD/AGENT	REACTION/ SIDE EFFECT	MEDICINE/FOOD/AGENT	REACTION/SIDE EFFECT

Have you ever had:	YES	NO	Have you ever had:	YES	NO	Have you ever had:	YES	NO
Hepatitis A,B, or C			Reactive Airway Disease (Asthma)			Attention Deficit Disorder/ADHD		
HIV			Pneumonia			Bipolar Disease		
Mononucleosis			Sinusitis			Depression		
Chicken Pox			Seasonal Allergies			Anxiety		
Measles (Rubeola)			Shortness of Breath/fatigue (esp. with exercise)			Panic Attacks		
Mumps			Unexplained fainting			Suicide Attempts		
German Measles (Rubella)			Thyroid Disease			Learning Disability		
Tuberculosis			Diabetes			Eating Disorder		
Rheumatic/Scarlet fever			Hypoglycemia			Psychiatric Problems		
Gallbladder Disease			Arthritis			Alcohol/Drug Dependency		
Gastroesophageal Reflux Disease (GERD)			Back Problems			**FEMALE**		
Liver Disease: explain			Headaches (Type)			Ovarian Cysts		
			Concussion: Date(s):					
Inflammatory Bowel Disease			Seizure Disorder			Breast Disease		
Polyps (Colon)			Multiple Sclerosis			Pelvic infections		
Heart Disease, Heart Murmur or Heart Infection Explain:			Cancer			Past Pregnancy		
High/Low Blood Pressure			Tumor/Cyst: Benign Malignant			Irregular Periods		
Chest pain/discomfort upon exertion			Anemia			Excessive Cramping		
Eye Disorders/Disease Describe:			Physical Disabilities Describe:			**MALE**		
Ear Disorders/Disease Describe:			**Any surgeries** Describe:			Hernia		
Dental disorders			Any broken bones:			Testicular Problems		

FAMILY HISTORY

Have any of your blood relatives had any of the following:

	Y	N	RELATIONSHIP		Y	N	RELATIONSHIP		Y	N	RELATIONSHIP
Arthritis				High Blood Press.				Kidney Disease			
Reactive Airway Disease (asthma)				Seizure Convulsions				Diabetes			
Tuberculosis				Cancer				Alcohol/Drug Dependency			
Heart Disease – i.e. Heart murmur, hypertrophy, irregular heart beat, Marfan's syndrome				Non accidental/ sudden death in immediate family before age 50				Close relative <50 with disability from heart disease			

CONSENT/AUTHORIZATION FOR TREATMENT & ACKNOWLEDGEMENT OF COSTS NOT COVERED: I certify that the information provided on this form is true and complete to the best of my knowledge. I realize that this information is confidential and for use by the Health Service staff. I give permission for myself to be evaluated, diagnosed and treated by Health Services, under the direction of a physician. I understand that under certain circumstances, or in an emergency, I may be referred to an area hospital, diagnostic testing facility, or medical specialist for evaluation, diagnosis, and/or treatment. I understand that Glennon Student Health Services provides care at no extra charge, however, costs for diagnostic testing, not covered by my insurance, are my responsibility.

STUDENT SIGNATURE	DATE	PARENT/GUARDIAN SIGNATURE (IF UNDER AGE 18)

FULL NAME	D.O.B.	ID#

PHYSICAL EXAMINATION BY HEALTHCARE PROVIDER **EXAM DATE: ____/____/_____**

- COMPLETED FORM IS A REQUIRED OF ALL STUDENTS
- PHYSICAL MUST BE COMPLETED WITHIN 1 YEAR OF ATTENDING LHU
- ATHLETIC EXAM MUST BE WITHIN 6 MONTHS OF THE START OF THE SPORT, AND THIS FORM MUST BE COMPLETED & SUBMITTED PRIOR TO ANY NCAA SPORT TRYOUT/PARTICIPTAION

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

DOES THE STUDENT HAVE AN ILLNESS/CONDITION NOT LISTED IN THE HISTORY, FOR WHICH TREATMENT IS REQUIRED? □YES □NO
PLEASE EXPLAIN ____

____

IS THE STUDENT UNDER TREATMENT FOR EATING DISORDER, BEHAVIORAL, OR PSYCHIATRIC PROBLEM? □YES □NO
PLEASE EXPLAIN ____

____

DOES THE STUDENT HAVE ANY PHYSICAL DISABILITIES OR ASSISTED DEVICES? □YES □NO
PLEASE EXPLAIN ____

____

CLINICAL EVALUATION	NORMAL	ABNORMAL FINDINGS (Please Explain)	INITIALS
MEDICAL			
BP T P R			
Height Weight			
Head, face, neck, and scalp			
Visual acuity and ophthalmic exam			
Ears/Nose/Throat/Sinuses/Mouth			
Lungs and chest			
Heart			
Abdomen			
Skin			
Neurological			
Concussion: Yes or No Date(s):			
G-U			
Menstrual History			
MUSCULOSKELETAL			
Neck			
Back/ shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/ankle			
Foot/toes			
REQUIRED FOR ATHLETES			
Heart murmur*			
Femoral pulses to exclude aortic coarctation			
Physical stigmata of Marfan syndrome			
Bilateral, brachial artery BP, sitting position+	Left	Right	

* Should be done supine and standing (or Valsalva maneuver) to identify (L) ventricular outflow obstruction +Preferably done in both arms

FULL NAME	D.O.B.	ID#

IMMUNIZATIONS

- **ALL IMMUNIZATIONS MUST BE CURRENT**
- **PLEASE CLEARLY PRINT DATE OF IMMUNIZATIONS IN ENGLISH**
- **IF NO DATES OF IMMUNIZATION AVAILABLE, ATTACH TITER RESULTS FOR EACH**

Vaccine				
Tdap		*one dose Tdap within 10 years		
Meningitis A,C,Y,W-135		*one dose Meningitis within 5 years If living on campus		
MMR			*two doses of MMR	
Varicella			*two doses of varicella OR date of disease ➡	
Hepatitis B				*three doses of Hep B *four doses of polio
Polio				

- IF NO DATES OF IMMUNIZATION AVAILABLE, PLEASE DO TITERS FOR EACH.
- ATTACH COPIES OF ALL TITERS.

TUBERCULOSIS (TB) TEST: ONE STEP TB TEST REQUIRED FOR ALL EDUCATION, HEALTH SCIENCE, AND ATHLETIC TRAINING MAJORS WITHIN 6 MONTHS OF CLASSES.

DATE APPLIED: ______________ DATE READ: __________________ RESULTS IN MM ____________________

**DATE APPLIED: ______________ DATE READ: __________________ RESULTS IN MM ____________________

IF POSITIVE RESULTS:

CHEST X-RAY **(ATTACH COPY)** DATE _________________RESULT_________________

MEDICATION TREATMENT ________________________________DURATION _______________

NURSING MAJORS ONLY TWO STEP TB TEST REQUIRED

- VARICELLA REQUIRED - 2 DOSES OR ATTACH COPY OF TITER
- HEPATITIS B REQUIRED - 3 DOSES OR ATTACH COPY OF TITER
- ANNUAL PHYSICAL EXAM REQUIRED WHILE IN PROGRAM
- MANTOUX TB TEST - 1ST LEVEL STUDENTS NEED 2 STEP TEST, 1-2 WEEKS APART
  - SINGLE MANTOUX TB TEST REQUIRED ANNUALLY THEREAFTER

STUDENTS: This entire form must be completed by you, and a health care provider (preferably your primary care provider) and the medical information supplied to us will become part of your LHU Glennon Student Health Services file. The information on the form will not be released to anyone without your knowledge and written consent except as permitted by the Family Education Rights and Privacy Act of 1974 and Health Insurance Portability & Accountability Act of 1996 (HIPAA) or as required by law.

FULL NAME	D.O.B.	ID#

ATTENTION PROVIDERS!

- FOR THE STUDENT TO TRYOUT/PARTICIPATE IN NCAA ATHLETICS, **BOTH SIGNATURE SECTIONS A & B MUST** BE **COMPLETED & SIGNED** BY HEALTH CARE PROVIDER (PHYSICIAN, PA-C, OR NURSE PRACTIONER)
- **SECTION B** MUST BE COMPLETED BY HEALTH CARE PROVIDER FOR ALL OTHER STUDENTS

Physical must be completed within 6 months prior to any athletic tryout/participation

A. MANDATORY FOR NCAA TRYOUT/PARTICIPATION - BOX MUST BE CHECKED & SIGNED

This student ☐is ☐ is not medically cleared to participate in intercollegiate athletics.

______________________________ ______________________________

HEALTH CARE PROVIDER SIGNATURE **DATE of Immunization Verification and Physical Exam**

B. MANDATORY FOR ALL STUDENTS - HEALTH CARE PROVIDER REPORT

I certify that I am a **DOCTOR/ PHYSICIAN ASSISTANT/NURSE PRACTIONER** legally qualified to practice medicine in the State Of ______________________________, have examined this student; that the above statements are correct; and that I find the student is neither mentally nor physically disqualified by reason of tuberculosis or any chronic or acute defect from successful performance as a college student, except as noted.

SIGNATURE OF HEALTH CARE PROVIDER		LICENSE NUMBER	
ADDRESS		CITY	
STATE	ZIP CODE	PHONE	FAX
PRINT NAME OF HEALTH CARE PROVIDER		DATE	

ALL Students:

CLK/2018

KEEP A COPY of this form, and any attachments, for your records

***ATHLETES: RETURN THIS ORIGINAL FORM TO GLENNON STUDENT HEALTH SERVICES.**
A COPY SHOULD BE GIVEN TO THE ATHLETIC TRAINER FOR YOUR SPORT.

ALL STUDENTS: Return COMPLETED form BEFORE beginning classes

Lock Haven University Glennon Student Health Services
401 North Fairview Street Lock Haven, PA 17745 570.484.2276 fax 570.484.2522