

# Lebanon Valley College

## Health Services • Report of Medical History

- Please complete this form before going to your physician for an examination.
- Information you provide is used solely as an aid to providing health care, if necessary, while you are a student.
- Information is strictly for the use of Health Services and is not released to anyone without your knowledge and consent.

Last Name (Print)	First Name	Middle	<input type="checkbox"/> Male <input type="checkbox"/> Female Sex
Home Address (Number and Street)	City or Town	State	Zip Code
Social Security Number		Date of Birth	
Name, Relationship of Parent or Guardian			Home Phone
Address of Parent or Guardian			Business Phone
In Emergency Notify: Name		Address	Phone

### FAMILY HISTORY

**Have any of your relatives ever had any of the following?**

	Age	State of Health	Occupation	Age at Death	Cause of Death		Yes	No	Relationship
Father						Tuberculosis			
Mother						Diabetes			
Brothers						Kidney Failure			
						Heart Disease			
						Arthritis			
						Stomach Disease			
						Asthma, Hay Fever			
Sisters						Epilepsy, Convulsion			
						Cancer			
						High Blood Pressure			

### PERSONAL HISTORY

**Please answer all questions.**

Have you had	Yes	No		Yes	No		Yes	No		Yes	No
Mononucleosis			Acne			Anemia			Bleeding Disorders		
Hepatitis			Insomnia			Palpitations (Heart)			Recurrent Diarrhea		
Chicken Pox			Frequent Anxiety			High Blood Pressure			Recurrent Constipation		
Gum or Tooth Trouble			Frequent Depression			Low Blood Pressure			Malaria		
Sinusitis			Worry or Nervousness			Rheumatic Fever			Hernia		
Eye Problem			Recurrent Nervousness			Heart Murmur			Sexually Transmitted Diseases		
Ear Problem			Hay Fever			Tumor, Cancer, Cyst			Herpes		
Nose Problem			Bronchitis			Jaundice			Thyroid Problem		
Throat Problem			Pneumonia			Gallbladder Trouble			<b>Females Only</b>		
Diabetes			Tuberculosis			Intestinal Trouble			Irregular Periods		
Seizures			Shortness of Breath			Stomach Trouble			Severe Cramps		
Eczema			Asthma			Recent Weight Gain			Excessive Flow		
Head injury with Unconsciousness			Chest Pain			Recent Weight Loss			Abnormal PAP Smear		
Cystic Fibrosis			Chronic Cough			Dizziness or Fainting			Pregnancy		
Neck Injury			Back Problems			Weakness, Paralysis			Cystic Breasts		
Do you drink alcohol?			Diseases/injury of joints			Bladder infection			<b>Males Only</b>		
Do you smoke?			Hearing Difficulty			Kidney Infection			Prostate Problems		
Do you want to quit smoking?									Lump or Mass in Testicle		

**ALLERGIES (Please list):** \_\_\_\_\_

## Health Services • Physician's Report of Health Evaluation

**TO THE EXAMINING PHYSICIAN:** Please review the student's history and complete the physician's form. Please comment on all positive answers. **THIS STUDENT HAS BEEN ACCEPTED.** The information supplied will not affect his/her status. All items marked with an \* are "REQUIRED" and must be completed or the form will be returned for completion. Chest x-ray is required if PPD is positive.

**IF THE STUDENT IS PARTICIPATING IN AN INTERCOLLEGIATE SPORT, YOUR SIGNATURE IS NECESSARY FOR SPORTS CLEARANCE.**

Male  Female

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Last Name (Print) \_\_\_\_\_ First Name \_\_\_\_\_ Middle \_\_\_\_\_ Sex \_\_\_\_\_

B/P \_\_\_\_\_ P \_\_\_\_\_ R \_\_\_\_\_ Height (inches) \_\_\_\_\_ Weight (lbs.) \_\_\_\_\_

\*Visual Acuity Screen: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ without glasses/contacts  
 Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_ with glasses/contacts

\*Urinalysis (required): Glucose \_\_\_\_\_ Protein \_\_\_\_\_ Leukocyte \_\_\_\_\_

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No	Description (if needed)
1. Head, ears, nose or throat	_____	_____	_____
2. Respiratory	_____	_____	_____
3. Cardiovascular	_____	_____	_____
4. Gastrointestinal	_____	_____	_____
5. Hernia	_____	_____	_____
6. Eyes	_____	_____	_____
7. Genitourinary	_____	_____	_____
8. Musculoskeletal	_____	_____	_____
9. Metabolic/Endocrine	_____	_____	_____
10. Neuropsychiatric	_____	_____	_____
11. Skin	_____	_____	_____

12. Is the patient now under treatment for any medical or psychological condition?  Yes  No

If yes, explain and list medications: \_\_\_\_\_

13. Is there loss or seriously impaired function of any paired organ?  Yes  No

If yes, explain \_\_\_\_\_

14. I certify that I have reviewed the medical history and examined the above student and should they choose to participate in intercollegiate athletics during their first year at LVC, I recommend:

- Clearance with no limitation
- Clearance pending further evaluation or testing
- Referral to other healthcare professional prior to clearance
- Clearance with limitations
- Disqualified from competition

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Healthcare Provider Information** (Physician, CRNP, PA-C, etc)

Name \_\_\_\_\_ Phone #/Fax # \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Stamp:

## Preadmission Immunization Policy

All incoming freshmen, transfer students and foreign exchange students are required to have the following immunizations completed according to these requirements before matriculating at Lebanon Valley College.

Male  Female

Last Name (Print)

First Name

Middle

Sex

**NOTE: STARRED IMMUNIZATIONS ARE MANDATORY; INCOMPLETE OR INCORRECT IMMUNIZATION REPORTS WILL BE RETURNED TO YOU.**

VACCINE	DATE
<b>DTP Series</b>	_____
<b>*TDAP/Adacel/Boostrix (Circle)</b> (Booster in last 10 years)	_____
<b>*OPV (polio) Series</b> Date, series and booster completed or titer_____	_____
<b>*MMR # 1</b> (if born after 1956) 2 doses or immune titer	_____
<b>*MMR # 2</b> 2 doses or immune titer	_____
<b>*Varicella Disease OR</b>	_____
<b>*Varivax vaccine # 1 AND</b> (chickenpox vaccine if born after 1979 or not born in the USA)	_____
<b>*Varivax vaccine # 2</b> per CDC guidelines: 2 vaccines	_____
<b>Meningococcal (Menatra)(A/C/Y/W-135)</b> <b>*Required of all residential students</b> (If primary dose administered before age 16 then a booster is required)	_____

RECOMMENDED BUT NOT REQUIRED	
VACCINE	DATE
<b>Hepatitis B #1</b>	_____
<b>Hepatitis B #2</b>	_____
<b>Hepatitis B #3</b>	_____
<b>HPV #1</b>	_____
<b>HPV #2</b>	_____
<b>HPV #3</b>	_____

TUBERCULOSIS	
<p><b>Tuberculosis Testing (PPD) within the last 12 months*</b> required regardless of prior BCG inoculation</p> <p><b>Date</b> _____</p> <p><b>Result:</b> <input type="checkbox"/> Neg <input type="checkbox"/> Pos</p> <p>Induration _____ mm</p> <p><b>Dates of INH Therapy</b> _____ to _____</p>	<p><b>If positive:</b> <b>Chest x-ray required</b></p> <p><b>Date</b> _____</p> <p><b>Results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>_____ Provider Signature</p>

**Healthcare Provider Information** (Physician, CRNP, PA-C, etc)

Name

Phone #/Fax #

Address

Signature

Date

(I have informed my patient of any immunization updates needed for completion of above required immunizations)

Office Stamp:

**Please make a copy of this entire form (for your records) before submitting and return only the original form to the Health Services Office.**

## Health Services • Consent for Treatment

Student Name: \_\_\_\_\_

Parental permission must be obtained before medical treatment can be rendered to persons under 18 years of age. The following consent form should be signed by a parent or guardian so that indicated care might be given with no unnecessary delay. No major procedures will be performed except in extreme emergency, without parents being notified and fully informed. In the event that a parent does not want treatment rendered under any circumstance, they should cross out the word "give" on the form below and circle the word "refuse." If the form is not signed, it will be interpreted as a refusal of permission.

"I give/refuse permission to the Consulting Physicians of Lebanon Valley College to carry out such emergency diagnostic and therapeutic procedures as may be necessary for my son/daughter, and in the physicians' absence, for the nurse on duty to render emergency care and other medical care in line with standing orders. I also permit such procedures to be carried out at and by one of the local hospitals in the event that my son/daughter has been sent or taken there for emergency care."

\_\_\_\_\_  
Signed

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Student

\_\_\_\_\_  
Date

### Insurance Information

**Insurance Data:** All full-time students are required to show proof of health insurance to the business office at Lebanon Valley College to assist with the cost of medical referrals, diagnostic testing and emergency treatment not provided by the College Health Center. In addition to this, Lebanon Valley College carries a secondary ACCIDENT insurance on all full-time students.

Name of Insured \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

Insurance Company Telephone (       ) \_\_\_\_\_

Group Number \_\_\_\_\_ Certificate Number \_\_\_\_\_

Member of Health Maintenance Organization (HMO)  Yes  No

Name of Primary Care Physician \_\_\_\_\_

Physician Telephone (       ) \_\_\_\_\_

**Return to: Health Services Office, Lebanon Valley College, 101 N. College Avenue, Annville, PA 17003-1400**  
**Deadlines: August 1 for fall registration • January 1 for spring registration**