

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.

Male Female

Last Name (Print)	First Name	Middle	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				
Sisters					Asthma, Hay Fever				
					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			Females Only		
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			Males Only		
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

Last Name (Print) _____ First Name _____ Middle _____ Sex _____

B/P _____ P _____ R _____ Height (inches) _____ Weight (lbs.) _____

*Visual Acuity: Right 20/ _____ Left 20/ _____ without glasses/contacts
 Right 20/ _____ Left 20/ _____ with glasses/contacts

*Tuberculin Skin Test or Chest X-ray: Date of Testing ____/____/____ Positive _____ Negative _____
 (Required within one year. Form will be returned if not completed.)

*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:

<input type="checkbox"/> Clearance with no limitation <input type="checkbox"/> Clearance pending further evaluation or testing <input type="checkbox"/> Referral to other healthcare professional prior to clearance <input type="checkbox"/> Clearance with limitations <input type="checkbox"/> Disqualified from competition	Comments _____ _____ _____ _____
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Physician's Name _____ Phone _____

Address _____

Physician's 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.

Last Name (Print) _____ First Name _____ Middle _____ Sex Male Female

INCOMPLETE OR INCORRECT IMMUNIZATION REPORTS WILL BE RETURNED TO YOU.

Measles (Rubeola) and German Measles (Rubella) epidemics continue to occur on American college campuses. A concerted effort must be made by colleges, students and their families for prevention of these diseases. Therefore, all entering students must present physician documentation of immunity as defined below before they will be permitted entrance to their residential hall room.

IMMUNITY TO MEASLES AND RUBELLA IS DEFINED AS FOLLOWS:

Rubeola (Measles)

1. Born before 1957, therefore considered immune. **OR**
2. Two measles vaccines administered after one year of age. (Specify month, day and year.)
3. Report of immune titer proving immunity.

NOTE: History of disease is not accepted.

Rubella (German Measles)

1. Rubella vaccine given after one year of age. (Specify month, day and year) **OR**
2. Report of immune titer proving immunity.

NOTE: History of disease is not accepted.

Also required:

1. Mumps vaccination with date or physician diagnosed disease.
2. Polio — completion of primary series with OPV (oral Sabin) total of three doses **OR** IPV (injected Salk) total of four doses.
3. Diphtheria, Pertussis, Tetanus Toxoid (DPT) **OR** Tetanus/Diphtheria (TD) which includes month and year. It must have been given within the past 10 years.
4. PPD Tuberculin Skin test (PPD) with complete date (month, day, year) and test results is required. If the PPD is positive, chest x-ray with date and test results is required. If the student has had BCG, a negative PPD or chest x-ray is required with date and test results.
5. Meningococcal Vaccine: One dose. (Resident Students)

Recommended but not required:

1. Hepatitis B Vaccine Series: Three doses.
2. Varicella: Suggested for students entering health occupations or occupations with exposure to young children who have not had the disease.
3. Meningococcal Vaccine: One dose. (Commuter Students)

Vaccines (list all dates; *required)

Vaccine	Date
*OPV/IPV Booster	_____ / _____ / _____
*MMR 1	_____ / _____ / _____
*MMR 2	_____ / _____ / _____
*DT	_____ / _____ / _____
Hep B 1	_____ / _____ / _____
Hep B 2	_____ / _____ / _____
Hep B 3	_____ / _____ / _____
Varicella	_____ / _____ / _____
*Meningococcal	_____ / _____ / _____

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