Medical History *(to be completed by student)*

Please complete this form before going to your health care professional for examination. This information is strictly for the use of the Student Health Center and will not be released to anyone without your knowledge and written consent.

Completion Date _____

Last Name (Student)	First Name	Middle	Sex ☐M ☐F	S.S. Number	Birthday
Permanent Mailing Address		City		State	ZIP
Home Phone	Marital Status ☐Single ☐Married ☐Divorced ☐Separated				

Height _____ Weight _____

Family History

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any blood relatives (children, brothers, sisters, parents or grandparents) had or currently have any of the following? *If yes, mark X in the small box and include the relationship (i.e. father, aunt) in the box to the right.*

Diabetes			Rheumatic fever			Blood disease		
Thyroid or goiter trouble			Arthritis, rheumatism			Tuberculosis		
Allergies			Strep throat			Stomach or ulcer trouble		
Asthma, bronchitis			Gout			Chronic diarrhea		
High blood pressure			Stroke			Other serious/chronic disease		
Coronary heart disease			Problems with alcoholism			Weight problem		
Other heart trouble			Cancer			Epilepsy		
Other:								

Do you smoke? ☐Yes ☐No If yes, how much per day? _____

Do you drink alcohol or use marijuana? ☐Yes ☐No If yes, how often per day? _____

Do you have any allergies to medication? ☐Yes ☐No If yes, please list: _____

Do you have any other allergies? ☐Yes ☐No If yes, please list: _____

Current medications _____

Past Medical History *(mark X if applicable and include date last treated in box to right)*

Alcohol/drug dependence			Dizziness/fainting			Psychological problem		
Allergy/hay fever			Ear and nose problem			Respiratory problem		
Anemia/blood disease			Epilepsy/seizures			Sexually transmitted disease		
Anxiety			Head injury			Shortness of breath		
Arthritis/joint pain			Heart problems			Skin problem		
Asthma			Hemorrhoids			Strep throat		
Back problems			Hepatitis			Swollen glands		
Bladder/kidney			High blood pressure			Swollen joints		
Blood in stool			High cholesterol			Thyroid disease		
Cancer/cyst/tumor			Hypoglycemia			Tuberculosis		
Clot in veins			Insomnia			Ulcer		
Constipation			Liver disease/jaundice			Varicose veins		
Depression			Malaria			Weight problem		
Diabetes (sugar)			Mononucleosis			*Other (describe)*		
Diarrhea			Pregnancy					

Sign Here: Student Signature *(Parent or Guardian if under 18 years of age)* _____

Medical Attention and Hospital Authorization

In the event that a student is ill and it is deemed necessary that he/she should have medical attention and/or hospitalization, I hereby authorize the designated representative of the College to:

- Secure the service of a health care professional
- Have him/her taken to a hospital for outpatient treatment
- Have him/her admitted to a hospital for in-patient treatment, including surgery

It is understood that this authorization will be used in case of an emergency and only when delay would jeopardize the student's welfare and when I cannot be reached immediately by telephone. It is understood that I will assume all financial obligations involved that are not covered by insurance.

Name of Healthcare Provider	Healthcare Provider Address (Street, City, State, ZIP)	Phone Number

Emergency Contacts *(please list two)*

Name	Address	Phone Number
Name	Address	Phone Number

Parents'/Guardians' Places of Employment *(list one or two)*

Relationship	Place of Employment	Business Phone
Relationship	Place of Employment	Business Phone

Sign Here: Student's Signature _____ Parent's Signature _____

Date _____ Date _____

Physical Examination *(to be completed by your health care provider)*

Please review the student's health history and complete this form, commenting on all positive answers. This student has been accepted at Thiel College and the information supplied will not affect student's status. It will be used only as a background for providing health care, if necessary. This information is strictly for the use of the Student Health Center and will not be released without the student's written consent.

Last Name	First Name	Middle	Sex ☐M ☐F	Blood Pressure	Weight	Height

If deemed necessary by health care provider completing this form:

Urinalysis Date _____ Sugar _____ Albumin _____ Micro _____

Hb. or Hct. _____

***Required Immunizations*:**

Tetanus/Diphtheria - must have received a primary series of DTP, DT of Td and a booster within past 10 years.
Measles, Rubella, Mumps - proof of vaccination or a titer is acceptable; primary injection with a booster.
Polio - primary series in childhood.
Varicella - either a history of chicken pox, Varicella antibody or two (2) doses of vaccine given at least one month apart if immunized after age 13; or one (1) dose of vaccine if immunized before age 12.
Hepatitis B - series of three (3) injections given at specific time intervals.
Meningococcal ACWY - All students that are residing in college or university-owned housing are required to have at least one (1) dose of the Meningococcal ACWY vaccine or a signed waiver declining the vaccine after being given literature on the vaccine and the disease. Meningococcal ACWY immunization must be administered ***within 5 years of campus entry***.

***Recommended Immunizations*:**

Influenza - annual immunization to avoid disruption to academic activities. These are given late fall providing they are not contradicted due to medical history or allergies.
Meningococcal B – recommended for students that are residing in college or university-owned housing. Consult with your physician for further information.

Update Immunizations Required for Admission unless otherwise noted:

	DATES	BOOSTERS
Diphtheria		
Pertussis		
Tetanus (within 10 yrs.)		
Polio		
Measles		
Rubella		
Mumps		
Varicella		
Influenza (recommended)		
Hepatitis B		
Meningococcal B (recommended)		
Meningococcal ACWY		

Tuberculosis Screening, if student is at risk (if positive, please list follow-up given)

☐Negative ☐Positive Date _____

Physical Examination *(continued)*

Are there abnormalities in the following systems? Describe fully. Use additional sheet if necessary. Check each item in appropriate column.

	Normal	Abnormal	Detail of each abnormality
Head, neck, face and scalp			
Nose and sinuses			
Mouth, teeth, gingiva and throat			
Ears – General (canals, drums, etc.)			
Eyes – General (lids, pupils, motions)			
Lungs, chest and breasts			
Heart			
Vascular system (including varicosities)			
Abdomen and viscera (include hernia)			
Ano-Rectal and pilonidal			
Endocrine system			
Genito-urinary system			
Upper extremities			
Lower extremities (include feet)			
Spine, other musculo-skeletal			
Skin and lymphatics			
Neurological system			
Psychiatric (personality deviation)			
If female, give menstrual history)			

Is there loss or seriously impaired function of any organ? ☐ Yes ☐ No

Recommendation for physical activity (PE, competitive sports, intramurals) ☐ Unlimited ☐ Limited

If there are limitations, explain _____

Is the patient under treatment or on any medication for any medical or emotional condition? Do you have any recommendations regarding the care of this student?

_____

Healthcare provider's signature _____ Date _____

Print health care provider name _____

Address _____ Phone _____

Meningitis Statement

The Advisory Committee on Immunization Practices (ACIP) of the U.S. Centers for Disease Control and Prevention (CDC) recommends that first-year college students living in residence halls should receive at least 1 dose of meningococcal conjugate vaccine (MCV4) before college entry. **All students who will be living in campus housing must submit proof of meningococcal vaccination that covers serogroups A, C, W, and Y in the last 5 years or less.**

Pennsylvania passed the Pennsylvania College and University Student Vaccination Act, which was signed into law on June 28, 2002. This law prohibits a student from residing in a dormitory or housing unit unless the student has received the required Meningococcal A, C, W, Y vaccination. The student **may elect to waive receiving the vaccination** for religious or other reasons. In this instance, the student **must sign a declination statement** that states he or she understands the risks and benefits of the vaccination and that they choose not to be vaccinated for religious or other reasons.

Although not mandated by Pennsylvania law, the CDC does recommend the meningococcal serogroup B vaccine for those at increased risk including: 1.) those exposed to a meningitis B outbreak; 2.) those with a damaged or removed spleen including people with sickle cell disease; 3.) anyone with "persistent complement component deficiency"; 4.) anyone taking a drug called eculizumab (also called Soliris) and 5.) Microbiologists who routinely work with isolates of N. meningitis.

What is meningococcal meningitis?
Meningitis is rare but potentially fatal bacterial infection. It can cause either inflammation affecting the brain and spinal cord or a systemic bacterial infection found in the blood. This can result in permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure or death.

How is it spread?
Meningococcal bacteria are transmitted through air droplets and direct contact with persons already infected with the disease. This can be through coughing, kissing, sneezing or sharing items like utensils, cigarettes and drinking glasses.

What are the symptoms?
Symptoms of meningococcal meningitis often resemble those of the flu. These symptoms include high fever, rash, vomiting, severe headache, neck stiffness, lethargy, nausea and sensitivity to light.

Who is at risk?
Anyone can get meningococcal disease but certain people are at increased risk, including adolescents and young adults 16 through 23 years old. Serogroups C, W, and Y cause the majority of meningococcal disease in the college age group. Research has shown that students residing in residence halls, particularly first-year students, are at higher risk for this type of meningococcal disease compared with college students overall.

Can meningitis be prevented?
A safe and effective vaccine is available that is 85 percent to 100 percent effective in preventing four serogroups of the disease which cause approximately 70 percent of the meningococcal diseases found in the United States. The vaccine is effective for approximately 3 to 5 years. Reactions to the meningitis vaccine are mild and infrequent consisting primarily of redness and pain at the injection site. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals. It does not protect against viral meningitis.

To learn more about meningitis and the vaccine, visit the websites for the CDC (www.cdc.gov/ncidod/dbmd/diseaseinfo) and the American College Health Association (www.acha.org).

This is a requirement to reside in Thiel College Housing. **Please check** the appropriate statement and sign below.

☐ **I have had the meningococcal A, C, W, and Y vaccination on _____. (date of vaccine)**

☐ I have read and understand the information about meningitis, and **I decline the meningococcal A, C, W and Y vaccine** at this time. If I decide later that I want the vaccine, I will obtain it from my private healthcare provider.

Sign Here: Student's Signature _____ Parent's Signature _____

Date _____ Date _____

***This will become part of the student's permanent file. The student will not be permitted to reside in campus housing if this form is not completed and returned prior to arrival on campus.**