EASTERN UNIVERSITY STUDENT HEALTH CENTER

Pre-Entrance Health Record Requirements for International Students

PLEASE ATTEND TO THIS IMMEDIATELY. YOUR ENROLLMENT IS NOT COMPLETE AND
YOU WILL NOT BE PERMITTED TO MOVE INTO CAMPUS HOUSING UNTIL THESE
REQUIREMENTS ARE MET.

Attached are the required health forms for full-time International Students at Eastern University. Universities in
the United States are required to secure documents concerning health and immunizations for all students.
Although this information is required, it remains confidential to the Eastern University Health Center.

Forms and information needed: (All forms must be completed in English.)

1. Health History FORM - Must be filled out in full.

2. Physical Exam FORM
The exam must be recent (within the past six months) and signed by a medical professional with contact
information listed.

3. Immunizations FORM
Must include the following with accurate dates of administration:

- TB test - All International Students will receive a PPD test upon arrival to EU, if the result is positive,
the Quantiferon Gold blood test will be performed followed by a chest x-ray and other testing, if
necessary
- Hepatitis B – 3 shot series
- Varicella (chicken pox) – disease date or 2 shot series
- Tetanus booster – given within the past 10 years
- MMR (measles, mumps, rubella) – 2 doses
- Polio (IPV or OPV) Last date in series
- Meningitis Vaccine if living in university housing (or signed Waiver)

These documents must be returned to our University Health Center at the following address a minimum of one
month prior to arrival.

Eastern University Health Center
1300 Eagle Rd.
St. David’s, PA 19087
USA
Faxed documents are accepted to meet deadlines; however, originals should be brought with you if you fax them.

**International Students MUST enroll in the student group health insurance and may not waive for their first year.** After one year, they may enroll in an approved, comparable insurance plan and are required to sign a release form at the health center. International students/visitors who are in programs that are under four weeks long must purchase health insurance on their own through a US travel insurance provider such as [www.insuremytrip.com](http://www.insuremytrip.com). The plan MUST include repatriation costs, Doctor’s Office visits, hospitalizations, emergency room visits and medical airlift home. **TRAVEL INSURANCE IS NOT ACCEPTABLE INSURANCE FOR students in programs that last more than four weeks and for whom insurance is required.**

You can view the Eastern University Student Health Insurance program and policy on the web at:


We eagerly look forward to welcoming you when you arrive for your studies with us.

Sincerely,

Janet Topper, RN, BSN, CSN
Director Student Health Center
Phone: 610-341-5955
Fax: 610-341-5954
E-mail: jtopper@eastern.edu
EASTERN UNIVERSITY
IMMUNIZATION RECORD

NAME: ___________________________ DOB: _______________ SCHOOL ID# ____________

Note that the immunizations listed below are REQUIRED. Specify the medical or religious reason for any immunization that is not given. Documentation of immunity via TITERS is ACCEPTABLE.

A. M.M.R. (Measles, Mumps, Rubella) - TWO doses required. Students born before 1-1-1957 are exempt.

   Dates:  
   # 1 __/_____/____
   Mo. Day Year
   Titers (if available):  
   Immune _________
   Non-immune _________

   # 2 __/_____/____
   Mo. Day Year

B. TETANUS-DIPHTHERIA - (within the LAST 10 YEARS, and please indicate if Tdap is given)

   Date: ___/_____/
   Mo. Day Year

C. HEPATITIS B - THREE doses of vaccine or a positive Hepatitis surface antibody

   1. Dates:  
   # 1 __/_____/____
   Mo. Day Year
   # 2 __/_____/____
   Mo. Day Year
   # 3 __/_____/____
   Mo. Day Year

   Or:

   2. Hepatitis B Surface antibody Date: ___/_____/____ Result: Reactive ____ Non-reactive ____
   Mo. Day Year

D. TUBERCULOSIS SCREENING - PPD within the last 6 months (required regardless of prior BCG inoculation)

   1. PPD (Mantoux) Date: ___/_____/____ Result: (circle one) Negative____ mm induration
   Mo. Day Year
   Positive ____ mm induration

   2. If positive PPD, then Chest X-Ray with report within past 6 months Date: ___/_____/____
   Mo. Day Year

E. MENINGITIS – Must have one dose after age 16. (Required for all students residing in campus housing)

   1. Date: ___/_____/____
   Mo. Day Year

F. POLIO:

   1. Most Recent Booster Date: ___/_____/____
   Mo. Day Year

G. VARICELLA: (Either a history of Chicken Pox or TWO doses of the vaccine)

   Date: ___/_____/____
   Mo. Day Year
   Date: ___/_____/____
   Mo. Day Year

HEALTHCARE PROVIDER SIGNATURE: ___________________________ Date: ___________

Note that the immunizations listed below are REQUIRED. Specify the medical or religious reason for any immunization that is not given. Documentation of immunity via TITERS is ACCEPTABLE.
Information you provide will not be used to influence your situation at the University; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Student Health Services and will not be released to anyone without your knowledge and consent.

SCHOOL ID# __________  DOB: _________  Spring  Fall  20___

LAST NAME (Print)  FIRST NAME  MIDDLE INITIAL

Permanent Address: ____________________________

Home Phone: ___________  Cell Phone: ___________

FAMILY HISTORY

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>State of Health</th>
<th>DETAIL</th>
<th>Age/Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Brother(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

- Diabetes
- Heart Disease/Stroke/
  High Blood Pressure
- Cancer
- Asthma/Allergies
- Tuberculosis
- Alcohol/Drug Problem
- Depression

PERSONAL HISTORY – PLEASE ANSWER ALL QUESTIONS – Please comment on all positive answers.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>German Measles</td>
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<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mono-nucleosis</td>
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<td></td>
</tr>
<tr>
<td>More than 10 lb. weight gain or loss in past year</td>
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<td></td>
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<tr>
<td>Females: menstrual problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ear, nose, throat problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penicillin allergy</td>
<td></td>
<td></td>
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<tr>
<td>Sulfas</td>
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<td></td>
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<tr>
<td>Head injury or Concussion</td>
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<td></td>
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<tr>
<td>Seizures</td>
<td></td>
<td></td>
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<tr>
<td>Migraines</td>
<td></td>
<td></td>
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<tr>
<td>Anxiety/depression</td>
<td></td>
<td></td>
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<tr>
<td>Sleep difficulty</td>
<td></td>
<td></td>
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<tr>
<td>Heart trouble/high blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Stomach/intestinal problems</td>
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<td></td>
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<tr>
<td>Eating disorder</td>
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<tr>
<td>Alcohol/drug problem</td>
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<td></td>
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<tr>
<td>Learning disability</td>
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<tr>
<td>Diseases/injury of joints</td>
<td></td>
<td></td>
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<tr>
<td>Back problems</td>
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<tr>
<td>Skin problems</td>
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<tr>
<td>Liver or kidney problems</td>
<td></td>
<td></td>
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<tr>
<td>Tumors or cysts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you drink alcohol?  Yes  No

Do you smoke cigarettes, cigars or use smokeless tobacco?  Yes  No

Do you take medications on a regular basis? (List)  Yes  No

Has your physical activity been restricted during the past five years? (Explain)  Yes  No

Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Explain)  Yes  No

Have you been hospitalized for any of the above?  Yes  No

Have you had any significant illness or injury for which you have been treated or hospitalized other than already mentioned? (Explain)  Yes  No

Do you have any questions in regard to your health, family history, or other matters:

Student’s Signature ____________________________  Health Care Provider’s Signature ____________________________  Date __________

INSURANCE INFORMATION – PLEASE SEND A PHOTO COPY OF FRONT AND BACK OF INSURANCE CARD.

Updated 8/12
EASTERN UNIVERSITY
PHYSICAL EXAMINATION

TO THE EXAMINER: PLEASE REVIEW THE STUDENT’S HISTORY AND COMPLETE THE PHYSICAL EXAMINATION AND IMMUNIZATION RECORD. PLEASE COMMENT ON ALL POSITIVE ANSWERS.

LAST NAME    FIRST NAME    MIDDLE
SEX: M F

Blood Pressure ________ Pulse ________ Height ________ inches Weight ________ lbs.

Are there abnormalities in the following systems? Describe fully. Use additional sheet if needed. Please comment on all positive findings.

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose, Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
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<tr>
<td>Cardiovascular</td>
<td></td>
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<tr>
<td>Gastrointestinal</td>
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<tr>
<td>Genitourinary</td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Neurologic</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Psychiatric</td>
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<td></td>
</tr>
</tbody>
</table>

Comments:

Is the patient now under treatment for any medical or emotional condition? Yes ______ No ______

Is the patient currently taking any medication on a regular basis? Yes ______ No ______

If yes, list medications: ____________________________________________

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

Recommendations for physical activity:
(Intercollegiate Athletics, Intramurals, Physical Education) Unlimited ______ Limited ______

Explain: _______________________________________________________________________________________

Do you have any further recommendations for the care of this student? Yes ______ No ______

Explain: _______________________________________________________________________________________

HEALTH CARE PROVIDER SIGNATURE: _________________________________

NAME: ________________________________________________________ DATE: __________________

ADDRESS: ______________________________________________________

PHONE: ________________________________________________________

Updated 8/12