Pre-Entrance Student Health Record

Attached are the **REQUIRED EU Health Forms** for **all first-year and transfer students.** The Health Center is committed to assuring your continued good health while you are a student at Eastern University.

1. **MEDICAL HISTORY FORM** – to be completed by student and reviewed by Health Care Provider at physical exam appointment.

2. **PHYSICAL EXAM FORM** – to be completed, signed and dated by Health Care Provider
   - To be completed within one year of school entrance. **After March 1st for athletes.

3. **IMMUNIZATION RECORD FORM** – to be signed and dated by Health Care Provider.
   - MMR - (Measles, Mumps, Rubella) – 2 Shot Series
   - TETANUS – Must have been given within the past 10 years
   - HEPATITIS B – 3 Shot Series
   - PPD Skin Test – *To be completed within 12 months of school entrance*. (All International Students will receive a PPD test upon arrival to EU.) If the result is positive, a follow-up chest x-ray or blood test will be required.
   - MENINGOCOCCAL - Required for all students residing in campus housing (or signed waiver)
   - MENINGOCOCCAL B - Required for all students residing in campus housing (or signed waiver)
   - POLIO - (IPV or OPV) - Last date in series
   - VARICELLA **-** (Chicken Pox) – 2 shot series or date of disease

4. **INSURANCE INFORMATION** – Photocopy of *front* and *back* of health insurance card

****IMPORTANT: All Health Forms are to be completed and submitted to the STUDENT HEALTH CENTER on or before August 1st.**

Students should make a copy of their health forms in the event they are required for other extra-curricular activities.

Sincerely,
Mary Thornton, RN
Phone: (610) 341-5955
Fax: (610) 341-5954

Eastern University
Student Health Services
1300 Eagle Road
St. Davids, PA 19087

EASTERN UNIVERSITY

1300 Eagle Road, St. Davids, PA 19087-3696

SPRING FALL 20___
Circle One

LAST NAME (Print) ______ **FIRST NAME** ______ **M.I.** ______ **BIRTH DATE** ______ **SCHOOL ID#** ______

FULL PERMANENT ADDRESS ______ **HOME PHONE** ______ **CELL PHONE** ______

MEDICAL HISTORY FORM

Medical History & Injury Questionnaire – *to be completed by student/student-athlete*

Social History

Marital Status:	__ Single	__ Married	__ Separated	__ Divorced
Living with:	__ Parents	__ Legal Guardian	__ Spouse	
No. of Siblings:	__ Brothers	__ Sisters		

Family Medical History

Have any of your relatives ever had any of the following medical conditions? Please list the family member.

	Yes	No	Family Member		Yes	No	Family Member		Yes	No	Family Member
Cancer	__	__	____________	Asthma	__	__	____________	High Blood Pressure	__	__	____________
Tuberculosis	__	__	____________	Stroke	__	__	____________	Marfan's Syndrome	__	__	____________
Diabetes	__	__	____________	Arthritis	__	__	____________	Epilepsy/Seizures	__	__	____________
Kidney Disease	__	__	____________	Heart Attack	__	__	____________	Sudden Death	__	__	____________
Heart Disease	__	__	____________	Stomach Ulcers	__	__	____________	(While playing Athletics or during exertion)			

Personal Medical History

Have you ever had, or do you now have, the following? If you are unsure, please ask your physician. Indicate by marking YES or NO to all of the following medical conditions.

	Yes	No		Yes	No		Yes	No
ADD/ADHD	__	__	Epilepsy	__	__	Migraine Headaches	__	__
Allergies (Food)	__	__	Fainting Spells	__	__	Mumps	__	__
Allergies (Medicine)	__	__	Fibromyalgia	__	__	Pleurisy	__	__
Allergies (Seasonal)	__	__	Gout	__	__	Rheumatic Fever	__	__
Anemia	__	__	Headaches (Frequent)	__	__	Scarlet Fever	__	__
Anxiety	__	__	Heart - Murmur	__	__	Shortness of Breath	__	__
Appendicitis	__	__	Heart - Palpitations	__	__	***Sickle Cell Trait**	__	__
Arthritis	__	__	Hemorrhoids	__	__	Sinusitis	__	__
Asthma	__	__	Hepatitis	__	__	Skin Disorder	__	__
Back Trouble	__	__	Hernia	__	__	Spitting/Coughing Blood	__	__
Blood in Urine	__	__	High/Low Blood Pressure	__	__	Stomach (Ulcers, Gastritis, Reflux)	__	__
Cancer	__	__	History of Blood Clots	__	__	Tendency to Bleed Easily	__	__
Chest Pain	__	__	HIV/AIDS	__	__	Thyroid Trouble	__	__
Chicken Pox	__	__	Infectious Mononucleosis	__	__	Tonsillitis	__	__
Chronic Bronchitis	__	__	Kidney Disease	__	__	Tuberculosis	__	__
Convulsions	__	__	Kidney Stones	__	__	Venereal Disease	__	__
Depression	__	__	Measles	__	__	Weakness, Paralysis	__	__
Diabetes	__	__	Meningitis	__	__	Whooping Cough	__	__
Eating Disorder	__	__	Mental Illness	__	__	(Women) Atypical Menses	__	__

***Intercollegiate Athletes – if you answered yes to SCT, please complete SCT form provided by Athletic Department.**

MEDICAL HISTORY FORM (Continued)

____

LAST NAME (Print) **FIRST NAME** **M.I.**

Please explain any responses marked YES on previous page. Include month/year and outcome if applicable.

EASTERN UNIVERSITY

MEDICAL INFORMATION & EXAM FORM

Physical Examination – ***To be completed by Health Care Provider***

Student-Athlete Name: ____ Date: __________

Date of Birth: ____________________ Age: _________ Male: ☐ Female: ☐

Height: ___________________ Vision: R _____/_____ L _____/_____

Weight: ___________________ Contact Lenses? Yes No

Pulse: ___________________ Blood Pressure: ____________________________

Medical Examination

	OK	Problem	Comment
Eyes/Fundus			
Ears, Nose, Throat			
Mouth & Teeth			
Head & Neck			
Skin & Scalp			
Lymphatics			
Cardiovascular, Heart			
Chest, Lungs			
Thorax			
Abdomen			
Hernia			
Genitalia			
Neurologic			

Orthopedic Examination

	OK	Problem	Comment
Neck			
Shoulders			
Elbow, Hand & Wrist			
Back, Spine			
Hips, Thighs			
Knees			
Ankles			
Feet			
Flexibility			

1. Please list all PRESCRIPTION MEDICATION you are currently taking:

Medication Name	Medication Dosage	Reason for taking

____
LAST NAME (Print) FIRST NAME M.I.

2. Please list all OVER-THE-COUNTER MEDICATION you are currently taking:

Medication Name	Medication Dosage	Reason for taking

3. Please list all the NUTRITIONAL SUPPLEMENTS you are currently taking:

Medication Name	LIST THE INGREDIENTS (you may attach a photo-copy of the label)

4. **Participation Recommendations**:
***Required for ALL STUDENTS*

____ Full Unlimited Participation
____ Limited Participation, i.e.: ________________
____ Clearance Withheld Until: ________________
____ No Athletic Participation

____
HEALTH CARE PROVIDER NAME (PLEASE PRINT)

ADDRESS: ____

PHONE: ______________________________ FAX: ______________________________

HEALTH CARE PROVIDER SIGNATURE: ____________________________ Date: ______

****Signature acknowledges that the Health Care Provider has reviewed Medical History and completed Physical Exam.**

INSURANCE CARD -- ***PLEASE ATTACH COPY OF INSURANCE CARD BELOW (FRONT AND BACK)***

Front	**Back**

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.

Dates: # 1 ____/______/_____ # 2 ____/______/_____ ***OR TITERS WITH REPORTS***

Mo. Day Year Mo. Day Year

B. Tdap – (Tetanus, Diphtheria, Acellular Pertussis) - MUST be within the LAST 10 YEARS

Date: _____/ ______/______

Mo. Day Year

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

1. **Dates:** # 1 _____/______/_____ # 2 ____/______/_____ # 3 ____/______/_____

Mo. Day Year Mo. Day Year Mo. Day Year

OR

2. **Hepatitis B Surface Antibody:** ***TITER WITH REPORT***

D. TUBERCULOSIS SCREENING - PPD within the last 12 months (required regardless of prior BCG inoculation)

1. PPD (Mantoux) **Date:** ____/ ______/_____ **Result:** ______ mm induration

Mo. Day Year

2. **If positive PPD,** then student may choose to have **either a chest x-ray or a Quanti Feron TB Gold blood test** performed. Copy of lab results is required. If you have completed INH therapy, please provide documentation.

E. MENINGOCOCCAL – Series of 2 OR 1 dose after age 16. (Required for all students residing in campus housing)

Dates: # 1 _____/______/_____ # 2 ____/______/_____

Mo. Day Year Mo. Day Year

F. MENINGOCOCCAL B

Dates: # 1 _____/______/_____ # 2 ____/______/_____

Mo. Day Year Mo. Day Year

G. POLIO:

Most Recent Booster **Date:** ____/_____/_____ ***OR TITER WITH REPORT***

Mo. Day Year

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

Dates: # 1 ____/_____/_____ # 2 ____/_____/_____ ***OR TITER WITH REPORT***

Mo. Day Year Mo. Day Year

****HEALTH CARE PROVIDER SIGNATURE: ____________________________Date: _____________**