

Health Status Report

Deadline: June 24

The Health Status Report must be completed in its entirety prior to arriving at Allegheny College.

Legal Last Name Legal First Name Chosen/Preferred Name Middle Initial Gender

Home Address (Number and Street) City/Town State ZIP Code

Date of Birth Student Cell Phone Number

Parent/Guardian Name and Address Parent Cell Phone Number

Parent/Guardian Business Address Business Phone Number

List of Colleges You Have Attended Citizenship

Primary Medical Care Provider Phone Number

PRIMARY INSURANCE INFORMATION

Name / Address of Subscriber Subscriber Date of Birth

Insurance Company Name

Insurance Company Address and Phone Number

Member ID Number Group Number

Preauthorization Required _____ Yes _____ No
for Medical Procedures or
Hospitalizations?

CONSENT FOR MEDICAL CARE

I authorize the medical personnel of Winslow Health Center to administer medical and/or surgical services to me, to perform emergency procedures as necessary, and to refer me to duly licensed medical personnel (including transfer to outside medical facilities) in the event a health care condition may arise that cannot be handled at Winslow. I further authorize Meadville Medical Center to release any medical information provided to me while enrolled at Allegheny College to Winslow Health Center.

Applicant's Signature if over age 18

Parent/Guardian Signature if Applicant is under age 18

Immunization Report

Deadline: June 24

This form must be completed and signed by a health care provider.
(Do not attach list)

NAME: Last

First

MI

Date of Birth

REQUIRED IMMUNIZATIONS

REQUIRED VACCINES	Dates Given	Recommended Dosing Schedule
MMR	#1____/____/____ #2____/____/____	2 doses OR positive titers Minimum of 4 weeks between doses 1 st dose given after 1 st birthday
Measles	#1____/____/____ #2____/____/____ OR Positive Titer Date:____/____/____	Option of combined MMR OR Individual vaccines
Mumps	#1____/____/____ #2____/____/____ OR Positive Titer Date:____/____/____	
Rubella	#1____/____/____ #2____/____/____ OR Positive Titer Date:____/____/____	
Tdap	Tdap ____/____/____	Tdap booster within last 10 years
Meningococcal (dose at age 16 or older) MCV4 (required) Meningitis B. (recommended)	____/____/____	One dose given at age 16 or older
Varicella (Chickenpox)	#1____/____/____ #2____/____/____ OR History of Disease:___Yes ___No Date____/____/____	2 doses varicella OR history of disease Minimum of 12 weeks apart if vaccinated between 1 and 12 years of age and at least 4 weeks apart if vaccinated at age 13 years or older
Hepatitis B	#1____/____/____ #2____/____/____ #3____/____/____	3 doses Usual schedule at 0, 1 and 4 months Minimum 4 weeks between doses 1 and 2 Minimum 3 months between doses 2 and 3 Minimum 4 months between dose 1 and 3

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RECOMMENDED IMMUNIZATIONS

RECOMMENDED VACCINES	Dates Given	Recommended Dosing Schedule
Hepatitis A	#1 ____/____/____ #2 ____/____/____	Recommended if planning to travel 6-12 months between doses
HPV	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____	Health Care Maintenance
Polio	Primary Series: ____ Oral ____ Injectable Most Recent Booster ____/____/____	Primary Series

Signature of Primary Health Care Provider

Date

Print Name of Health Care Provider

Deadline: June 24 Medical History Report

To be completed by student and signed by health care provider.
Please complete prior to visiting your health care provider for physical examination.

Student Name _____

Date of Birth _____

Family History

	Age	State of Health	Occupation	Age at Death	Cause of Death	Have any of your relatives ever had any of the following: YES		Relationship
Father						Alcohol/substance abuse		
Mother						Cancer		
Brother(s)						Tuberculosis		
						Diabetes		
						Kidney Disease		
Sister(s)						Stomach Disease		
						Asthma, Hay Fever		
						Seizure Disorder		

Personal History: Please answer all questions.

Have you had:

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia			Dizziness/Fainting			Kidney Disease/Stones			Sexually Transmitted Infections		
Anxiety			Ear/Nose/Throat Trouble			Learning Disability/ADD/ADHD			Sickle Cell Disease		
Appendectomy			Eye Trouble			Loss of Paired Organ			Sports Injuries		
Arthritis			Gallbladder Trouble			Malaria			Stomach/Intestinal Trouble		
Asthma			Gum/Tooth Trouble			Measles			Tuberculosis Disease		
Back Problems			Hay Fever			Measles (German)			Ulcer/Stomach Problem		
Bipolar Disorder			Head Injury with unconsciousness			Migraines			Urinary Infection		
Blind/Visual Impairment			Headache (recurrent)			Mononucleosis			UTI's (frequent/recurrent)		
Cancer			Heart Disease			Mumps			Other (please list):		
Chicken Pox			Heart Palpitations			Neuromuscular Disease					
Concussion			Hepatitis			Pain/Pressure in Chest					
Chronic Cough			Hernia/Rupture			Pneumothorax					
Colds (recurrent)			High/Low Blood Pressure			Phlebitis/Deep Vein Clot			FEMALES ONLY		
Crohn's/Colitis/IBS			High Cholesterol			Recent Weight Gain/Loss			Irregular Periods		
Deaf/Hearing Impaired			HIV Infection			Rheumatic Fever/Heart Murmur			Severe Cramps		
Depression			Impaired Mobility/Paralysis			Scarlet Fever			Excess Flow		
Diarrhea (recurrent)			Jaundice			Seizure Disorder			Pregnancy		

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates – attach additional sheet if needed):

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Inpatient Hospitalizations: Please list all medical and/or psychiatric hospitalizations with dates/diagnoses:

Allergies to medications: ____ No known allergies ____ Yes

If yes, please specify _____

Winslow Health Center may share select information from this form with the Counseling and Personal Development Center as deemed necessary by the Director of WHC unless the student requests in writing to WHC that this information not be shared.

Student Signature Date

Health Care Provider Signature (Acknowledging Review)

Medications: Please list details of all current medications.

Report of Physical Examination

Deadline: June 24

A physical examination must have been completed within the past 12 months.

TO THE EXAMINING HEALTH CARE PROVIDER:

Please review the student's history and complete this form. Please comment on all positive answers. THIS STUDENT HAS ELECTED TO ENROLL. The information supplied will not affect his/her status; it will be used only as informational purposes for providing health care, if necessary. This information is strictly for use by the professional medical staff of Allegheny College and will not be released without student consent.

Last Name

First Name

Middle Initial

Gender

BP

Height - Feet/Inches

Weight - Lbs

List Drug Allergies

Will you be participating in a college sponsored (non-club) sport? ___ Yes ___ No

Sport: _____

Are there abnormalities of the following systems:

	NO	YES	Describe fully. Use an additional sheet if needed.
Head, Ears, Nose, or Throat			
Eyes			
Respiratory			
Cardiovascular			
Musculoskeletal			
Hernia			
Gastrointestinal			
Genitourinary			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

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Is there any ongoing medical treatment that should be continued while the student is attending Allegheny College, including counseling?

_____ Yes _____ No

If yes, please explain _____

Is there loss or seriously impaired function of any organ?

_____ Yes _____ No

Physical Education Requirement (PE / Intramurals / Other): Explain any limitations: _____

Health Care Provider's Signature _____

Date _____

Print Last Name _____

Address _____

Tuberculosis Risk Assessment

Deadline: June 24

This form must be completed and signed by a health care provider.

NAME: Last

First

MI

Date of Birth

Have you had close contact with anyone who was sick with tuberculosis (TB)?	___ Yes ___ No
Were you born in a country with a high incidence of active TB Disease?	___ Yes ___ No
Have you traveled or lived for more than a month in one of the countries with a high rate of TB? (Please see "high incidence" list.)	___ Yes ___ No
Have you had frequent or prolonged visits to one or more of the countries with a high incidence of TB disease?	___ Yes ___ No
Have you been a resident and/or employee of a high-risk congregate setting (e.g. correctional facilities, long-term care facilities, homeless shelters)?	___ Yes ___ No
Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	___ Yes ___ No
Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease (e.g. medically underserved, low-income, drug/alcohol abusers)?	___ Yes ___ No

If you answered YES to any of the above questions, either a PPD test (Mantoux) OR Interferon Gamma Release Assay (IGRA) must be completed within 12 months prior to entering Allegheny College.

PPD (Mantoux) Test: Date Read: _____ (mm/dd/yy)	Results (in mm of induction): _____ mm
OR	
IGRA DATE: _____ (mm/dd/yy)	Result (circle): Positive Negative

Chest X-ray required if PPD is positive (10mm or more), OR if IGRA is positive

Date Performed: _____ (mm/dd/yy) Results (circle): Normal Abnormal (send report)

If you have had a positive PPD in the past, irrespective of BCG history, and not been treated, Chest X-ray is required. Document Above.

If you have been treated for a positive PPD, no further testing required. Document below.

Treatment for positive PPD? YES Describe: _____

Signature of Health Care Provider (required) Date

Printed Name of Health Care Provider (required)

Countries with High Incidence of Tuberculosis (TB)

("High Incidence" is defined as areas with reported or estimated incidence of ≥ 20 cases/100,000 population)

Afghanistan	Dominican Republic	Malaysia	Sao Tome and Principe
Algeria	Ecuador	Maldives	Senegal
Angola	El Salvador	Mali	Serbia
Argentina	Equatorial Guinea	Marshall Islands	Seychelles
Armenia	Eritrea	Mauritania	Sierra Leone
Azerbaijan	Estonia	Mauritius	Singapore
Bahrain	Ethiopia	Mexico	Solomon Islands
Bangladesh	Fiji	Micronesia (Federated States of)	Somalia
Belarus	Gabon	Mongolia	South Africa
Belize	Gambia	Morocco	South Sudan
Benin	Georgia	Mozambique	Sri Lanka
Bhutan	Ghana	Myanmar	Sudan
Bolivia (Plurinational State of)	Guatemala	Namibia	Suriname
Bosnia and Herzegovina	Guinea	Nauru	Swaziland
Botswana	Guinea-Bissau	Nicaragua	Tajikistan
Brazil	Guyana	Niger	Thailand
Brunei Darassalam	Haiti	Nigeria	Timor-Leste
Bulgaria	Honduras	Niue	Togo
Burkina Faso	India	Pakistan	Trinidad and Tobago
Burundi	Indonesia	Palau	Tunisia
Cabo Verde	Iran (Islamic Republic of)	Panama	Turkey
Cambodia	Iraq	Papua New Guinea	Turkmenistan
Cameroon	Kazakhstan	Paraguay	Tuvalu
Central African Republic	Kenya	Peru	Uganda
Chad	Kiribati	Philippines	Ukraine
China	Kuwait	Poland	United Republic of Tanzania
Colombia	Kyrgyzstan	Portugal	Uruguay
Comoros	Lao People's Democratic Republic	Qatar	Uzbekistan
Congo	Latvia	Republic of Korea	Vanuatu
Côte d'Ivoire	Lesotho	Republic of Moldova	Venezuela (Bolivarian Republic of)
Democratic People's Republic of Korea	Liberia	Romania	Viet Nam
Democratic Republic of the Congo	Libya	Russian Federation	Yemen
Djibouti	Lithuania	Rwanda	Zambia
	Madagascar	Saint Vincent and the Grenadines	Zimbabwe
	Malawi		