HEALTH STATUS REPORT

Deadline: June 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

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 for Medical Procedures or Hospitalizations? _____ Yes _____ No

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

ALLEGHENY COLLEGE

IMMUNIZATION REPORT

Deadline: June 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

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 1st dose given after 1st 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

RECOMMENDED VACCINES	Dates Given	Type
COVID-19	#1____/____/____ #2____/____/____ (if applicable)	☐ Pfizer-BioNTech ☐ Moderna ☐ Johnson & Johnson ☐ _____

_____

Signature of Primary Health Care Provider **Date**

_____

Print Name of Health Care Provider

ALLEGHENY COLLEGE

MEDICAL HISTORY REPORT

Deadline: June 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

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
Father					
Mother					
Brother(s)					
Sister(s)					

Have any of your relatives ever had any of the following:	YES	Relationship
Alcohol/substance abuse		
Cancer		
Tuberculosis		
Diabetes		
Kidney Disease		
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):

_____

_____

_____

_____

CONTINUE TO BACK

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 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

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			

CONTINUE TO BACK

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_____

ALLEGHENY COLLEGE

TUBERCULOSIS RISK ASSESSMENT

Deadline: June 30

Mail to Allegheny College, Winslow Health Center, 520 N. Main Street, Meadville, PA 16335

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