**RETURN FORM TO:** Cheyney University of Pennsylvania Health Services Phone: 610 399 – 2260 Fax 610 399 - 2566
1837 University Circle, Cheyney, PA 19319


# REPORT OF MEDICAL HISTORY
## Mandatory for All Students

**Other Students:** **May be required for class scheduling of some academic majors i.e. Education, Health Sciences, other, etc.**

Last Name_____ First Name_____ Middle Initial____ Student ID_____

Home Address_____ ❑ Male ❑ Female

City_____ State_____ Zip_____

Student Cell Phone#_____ Home Phone #_____ Birthday_____

Parent/Guardian/Emergency Contact Name_____ Contact Phone #_____

**ENROLLMENT STATUS** (check all that apply)

❑ Undergrad ❑ Graduate ❑ Transfer ❑ International ❑Exchange ❑Other _____

**MEDICAL HISTORY**

N/A_____
Allergies to Medications/ Seasonal _____
Diseases/Surgeries/Injuries/Chickenpox:_____
Daily Medications_____
Have you ever been diagnosed with depression/anxiety/or other psychological illness? (Please explain on separate sheet)
Other:_____

***MEDICAL RELEASE STATEMENT***

*By signing this, I affirm that all information in this document is correct and complete. I also agree to inform the Student Health Center of any changes in my health or in the information on this form. I grant permission to the staff of University Health Services to render any treatment necessary. I understand under certain circumstances or emergencies I may be referred to a hospital, diagnostic testing, or a medical specialist for diagnoses and /or treatment. Costs incurred for these services are the responsibility of the patient and I will be responsible for all bills incurred that are not covered by my health insurance carrier.*

*I authorize release of my medical records and information to my insurance company for the purpose of reimbursement.*
*I authorize the release of my medical records and information to a licensed physician, hospital, clinic, other medical personnel, including University Athletic Training Services and Counseling and Psychological Services, in the event of an emergency or continuation of care. This authorization shall remain in effect while enrolled at Cheyney University or written withdrawal of consent is received at University Health Services.*

_____ _____
*Student Signature (or Parent/Guardian if student is under 18 yrs)* *Date*

# IMMUNIZATIONS

## Mandatory for All Students

Other Students: **May be required for class scheduling of some academic majors i.e. Education, Health Sciences, other, etc.**

**Attach official documentation from a school, medical records, or have your physician complete this form**

** May attach official copies of reactive Titer test results, in lieu of vaccination dates, for MMR, Tetanus, Hepatitis B, or Varicella

*1. MMR (MEASLES/MUMPS/RUBELLA) Students born before JANUARY 1956 are exempt from MMR vaccinations*

*Dates: #1*_____ *# 2* _____

*2. TETANUS / TDAP (within past 10 years) Date:* _____ *3. Polio Series competed Date:* _____

*3. HEPATITIS B (Dates: #1* _____ *#2* _____ *#3*_____

*4.. TUBERCULOSIS Screening:*
*TB testing is REQUIRED for* □ *International Students,* □ *Non-USA born students,* □ students *who have been exposed to tuberculosis or are high risk*

TB PPD TEST done within past year: *DATE GIVEN:* _____ *DATE READ:* _____ *RESULTS:* _____ *mm Negative* _____ *mm Positive*

**OR** QUANTIFERON Test *DATE:* _____ *Results:* _____ □ attach copy of lab results

□ *Attach a Copy of Report of Chest X-ray for positive PPD or positive Quaniferon test* DATE:_____

□ *Treatment received for positive TB screening/CXR- DESCRIBE*_____

*5. MENINGOCOCCAL QUADRIVAVALENT A, C, Y, W-135: (after age 16)* ❑ YES Date: _____ ❑ NO
*(Required if living in University owned housing)*

□ *MENINGITIS WAIVER: Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of the vaccination, and has decided not to receive the vaccine, or has received the vaccine before age 16.*

_____ _____
*Student Signature* *(Parent/Legal guardian if student is under 18 yrs)* *DATE*

6. *VARICELLA: (optional) Dates: #1* _____ *#2* _____ OR Date of Disease: _____

*7. HPV Vaccine (optional) Dates: #1* _____ *#2* _____ *#3*_____

_____
*PHYSICIAN'S SIGNATURE (stamp not accepted)* *DATE*
*(If completed by PAC or NP include name of Physician Association)*
*** *Print Physician's Name* _____ *** *License #*_____ *Telephone #*_____

_____
*City or Town* *State* *Zip Code*

**International Students wishing to participate in Intercollegiate Athletics must also have their physician complete the Athletic Physical Examination Form**

# Cheyney University
## (International Students may only be exempted from Immunizations for a medical contraindication)

Student Name (Print) _____ Student ID# _____

*To be completed and signed by a Medical Care Provider and the Student*

*CHECK ONE*

1._____**PERMANENT** medical contraindication (state vaccine):_____

Explanation_____

2. _____**TEMPORARY** medical contraindication (state vaccine):_____

Explanation_____

Anticipated Date of End of Exclusion _____

3._____**DECLINED VACCINE** for personal or religious reasons:

The Student has been advised of the risks, the effectiveness, and availability of vaccines and **has decided not to receive the vaccine(s) checked below:**

❑ Hepatitis B ❑ Tetanus/Diphtheria ❑ Pertussis ❑ Measles ❑ Mumps ❑ Rubella
❑ Meningococcal Quadrivalent *A, C, Y, W-135: (after age 16)* ❑ Varicella

❑ Tuberculosis testing:.
(Non-US born students, International students, and high risk students may not be exempt. TB testing is required for health and education related majors.) http://www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_Apr2011.pdf

**I am unable to comply with the Cheyney University Policy as set forth in. I understand that if an outbreak of communicable disease occurs I may be required to leave campus immediately for a period of time determined by the University. This may negate my attending classes for this period of time.**

** **Student Signature** (REQUIRED) **Date**

** **Signature of MD, NP, PAC, NP (Stamp not accepted)** **License #** **Date**
If completed by PAC or NP print name of Physician Affiliation

Print Name of Medical Provider

Street Address City State Zip

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