



California University of Pennsylvania
 Building Character. Building Careers.
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 A proud member of the Pennsylvania State System
 of Higher Education.

University Wellness Center
 Carter Hall
 250 University Avenue
 California, Pennsylvania 15419-1394
 Phone: (724) 938-4232 FAX:(724) 938-4509

ATHLETES
 It is your responsibility
 to make a copy of
 this form and send
 it to the
 Athletic Department
 and send the original
 to the Health Center.

MEDICAL INFORMATION FORM

Date of Admission:

Please make a copy of all forms for your personal records.

Summer ___ Spring ___ Fall ___ 20 ___

___ Check here if you are an International student

Student Information: ___ Male ___ Female

Name: _____
 Last

_____ First Middle Name

Home Address: _____
 Street

_____ City State Zip Code

Phone: (Area Code) _____
 Date of Birth: _____
 CWID: _____
 Citizen of: ___ USA ___ Other _____
 Name of Country

Emergency Notification:

Name: _____

Relationship: _____

Address: _____
 Street

_____ City State Zip Code

Home Phone: (Area Code) _____
 Cell Phone: (Area Code): _____
 Work Phone: (Area Code) _____

Required Medical Insurance - Lack of insurance or inadequate coverage will result in automatic enrollment in the University sponsored Student Health Insurance Program. *The documentation of the health insurance on this form does not fulfill the requirement of the University Hard Waiver.

Insurance Company Name: _____

Insurance Company Address: _____

Policy Holder's Name: _____

Policy Holder's Home Address: _____

Policy Number: _____ (ID Number) Group Number: _____

I hereby give permission to the University Wellness Center Nurse/Nurse Practitioner or MD Physician of his/her choice, to prescribe necessary medication and/or perform treatments necessary in the best interest of my health needs. I understand that my parents or guardians will be notified of any serious illness or hospitalization (Only incoming students under 18 years of age must have medical information form notarized).

 (Signature of Student) (Date) (Signature of Parent or Guardian of Minor)

California University of Pennsylvania Student Health Center Office Use Only

Insurance Information Complete? ___ Yes ___ No CWID# _____

Medical Information Form and Physical Exam Complete? ___ Yes ___ No

Record is incomplete or requires follow-up for:
 PPD: _____ Hx: _____ Physical: _____ Form Reviewed By _____

Personal Health History

CWID # _____			
(Last Name)	(First Name)	(Middle Name)	
Have you had?	Yes	No	
Rheumatic/Scarlet Fever			
Measles (Rubeola))			
German Measles (Rubella)			
Mumps			
Chicken Pox			
Tuberculosis			
Diabetes			
Heart Disorders			
High or Low Blood Pressure			
Kidney Disorders			
Tumor/Cancer			
Hepatitis (Specify Type)			
Epilepsy/Seizure Disorder			
Mononucleosis			
Stomach/Intestinal diseases (specify)			
HIV/AIDS			
Eye disorders/disease			
Recurrent Sinusitis			
Recurrent ear infections			
Seasonal allergies			
Asthma			
Allergy injections			
Thyroid Conditions			
Other			
Have you been treated or hospitalized for:	Yes	No	
Anxiety			
Depression			
Hyperactivity/ADD			
Bipolar illness			
Eating disorders (Specify)			
Head injury			
Other			
Surgical Procedures:			
Appendectomy			
Tonsillectomy			
Other:			
Bone/joint surgery/disease (Specify)			
Allergies to Medicines: (Specify)			
Allergies to Food & Additives: (Specify)			

FAMILY HISTORY

Have any of your relatives had any of the following conditions?							
	Yes	No	Relationship		Yes	No	Relationship
Tuberculosis				Cancer (Specify)			
Diabetes				Asthma			
Kidney Disease				Epilepsy			
Heart Disease				Alcohol/Drug Abuse			

Remarks and Additional Information: _____

Immunization Record

		CWID# _____
(Last Name)	(First Name)	(Middle Name)

IMMUNIZATION REQUIREMENTS

Due to the regular incidence of dangerous communicable diseases on college campuses, the American College Health Association has asked that all colleges and universities institute an immunization policy which would require proof of sufficient immunity prior to class registration. In keeping with this, the California University Student Health Center has developed immunization requirements which must be met prior to class registration.

Measles (Rubeola) Immunization must be performed with "live" measles vaccine on or after the first birthday. If born in or after 1957, documentation of a second dose of vaccine is required. Administration of a second MMR II is recommended by the CDC. A history of the disease is not adequate proof of immunity. Mumps Immunization must be performed after the first birthday.

Primary and secondary schools in all states now require current immunizations. You may contact your high school for a copy of your immunization record. We thank you for your cooperation.

***Waiver of these immunization requirements occurs only in case of medical contradiction, documented by your physician or religious objection, documented by your religious leader.**

PLEASE COMPLETE
Tuberculin Skin Test PPD by Mantoux Method
Date of test: _____ <i>Mandatory (within the past 12 months)</i>
Mandatory Signature
Date of reading: _____
Negative... _____ mm
Positive... _____ mm
Treatment: _____
Mandatory Signature
or
Chest X-ray _____ Date: _____
Negative... _____
Positive... _____
Treatment: _____
Mandatory Signature

Immunization Record Please List All Dates	Date of Last Immunization
DPT -	
Polio -	
MMR I -	
MMR II -	
Measles(Rubeola) -	
Mumps -	
Rubella (German Measles) -	
Varicella (Chickenpox) -	
Tetanus - Td (within the last 10 years)	
Hepatitis B (RECOMMENDED) - List Dates	
Dose 1: _____ Dose 2: _____ Dose 3: _____	
Meningitis Vaccine -	

Pennsylvania State Law requires ALL students residing in residence halls provide proof of meningitis vaccine or sign a waiver.

THIS SECTION IS FOR YOUR PHYSICIAN TO COMPLETE
Physical Examination

			CWID# _____
(Last Name)	(First Name)	(Middle Name)	

<input type="checkbox"/> Male <input type="checkbox"/> Female					
BP: _____ / _____	Ht: _____	Wt: _____ lbs.			
Corrected Vision: R20/ L 20/	Uncorrected Vision: R20/ L20/				
Assessment of Hearing Acuity: _____			Assessment of Dental Hygiene: _____		

Medications (List Each Dosage)

1: _____	Dosage _____
2: _____	Dosage _____
3: _____	Dosage _____

Drug Allergies: _____ Type of Reaction: _____

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

General Comments? _____

Recommendations for physical activity (Physical Education, Athletics, etc.) Unlimited: _____ Limited: _____

Explain: _____

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

If yes, please explain: _____

Do you have any recommendations regarding the care of this student? Yes _____ No _____

If yes, please explain: _____

Are there any abnormalities of the following systems? Describe fully. Use an additional sheet if necessary.

	Yes	No
Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		

	Yes	No
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		

Comments: _____

(Physician's Signature)

Date: _____

(Physician's Name - Printed)

Address: _____

Phone#: _____