



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

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

Date of Admission:

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) _____ Cell: _____

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) _____

***It is MANDATORY that ALL F-1VISA International Students and ALL NCAA Athletes must show proof of Health Insurance. For any student who wants to purchase coverage, information can be found at www.calu.edu/Student Health Insurance or at www.chpstudent.com.**

PLEASE PROVIDE YOUR CURRENT HEALTH INSURANCE INFORMATION:

Insurance Company Name: _____

Insurance Company Address: _____

Policy Holder's Name: _____ DOB: _____

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)

Do you or have you ever 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		
Sickle Cell Anemia		
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.**

<u>PLEASE COMPLETE</u>
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 – (ACWY) Date: _____	
Meningitis B Vaccine: Dose 1: _____ Dose 2: _____ Dose 3: _____	
HPV Vaccine (Gardasil) Dose 1: _____ Dose 2: _____ Dose 3: _____	
* <i>Athletes:</i> Sickle Cell Testing - Positive _____ Negative _____	Testing Date

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

****Effective August 1, 2012 Sickle Cell testing is mandated for all athletes. Athletes will need to take a test, provide proof that they have already taken a test, or sign a waiver to opt out.***

THIS SECTION IS FOR YOUR PHYSICIAN TO COMPLETE
Physical Examination

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

Male	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#: _____