JUNIATA COLLEGE STUDENT HEALTH INFORMATION SHEEET

(To be completed by student)

_____ _____ _____ _____

Last Name First name MI Date of Birth Gender Graduating Class

_____ (_____)_____

Street Address City/Town State Zip Student Cell Phone

_____

Parent/Guardian Address

(_____)_____ (_____)_____ (_____)_____

Home Phone Business Phone Cell Phone

_____ (_____)_____ (_____)_____

Emergency contact (other than parent) Home Phone Business Phone

INSURANCE INFORMATION - ***Attach a copy of your insurance card (front and back) for our records*.** The student should also carry his or her own insurance card with them while they are at school.

Subscriber's name_____ Relationship to student_____

**If prior approval is needed for lab work, referrals or hospitalizations, please provide the student with the necessary information so he/she can get approvals. The Health Center is not responsible for obtaining prior authorizations and approvals.*

HEALTH INFORMATION

Chronic health problems (i.e. asthma, diabetes, etc.), disabilities, special needs _____

_____

Current medications_____

Do you have any allergies to medication? Yes ____ No____ List_____

Do you have any other allergies? Yes____ No_____ List_____

Have you ever had surgery? If so, when and what? _____

CONSENT FOR MEDICAL CARE – *for parents/guardians of applicants under 18 years of age only*

I, _____, as parent/guardian of_____

(print your full name) (print student's full name)

do hereby authorize the staff at the Juniata College Health & Wellness Center to provide routine medical care to my child. This may include ordering lab tests, performing physical exams, treatment of minor illnesses and injuries, and administering immunizations. I also authorize the Center staff to seek emergency medical care if necessary.
I understand that this authorization may be revoked, in writing, at any time.

Signed:_____ Date:_____

**Please note: Your health record will be kept on file at the Health & Wellness Center for seven years after graduation, at which time it will be destroyed.

IMMUNIZATION RECORD

Name:_____ DOB:_____

****To be completed and signed by your health care provider****

1. MEASLES, MUMPS, RUBELLA: Two immunizations for measles and one each for mumps and rubella are **required**. The earliest the first immunization can be given is 12 months of age.

1st MMR: _____/_____/_____
2nd MMR:_____/_____/_____ OR Measles (Rubeola) _____/_____/_____

OR documented positive titer Measles (Rubeola) _____/_____ Mumps _____/_____ Rubella _____/_____

2. MENINGITIS VACCINE date:_____/_____/_____ (**Required** to live on campus)

3. HEPATITIS B:
Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____

4. T-dap – should be within last 10 years: _____/_____/_____

5. VARICELLA history of disease (year) _____ OR vaccine dates: _____/_____/_____; _____/_____/_____

6. POLIO completed primary series of polio immunization yes ____ no _____
Date of last booster: _____/_____/_____ Type: OPV _____ IPV _____ EP-IPV _____

7. HEPATITIS A: First dose: _____/_____/_____ Second dose: _____/_____/_____

8. TB SCREENING within the year is required for students at **high risk** for TB as defined by the CDC (foreign born persons from high prevalence countries, persons with compromised immune systems, close contact with infectious TB cases)

TB skin test (PPD) Date_____/_____/_____ Results _____(mm induration)

If more than 5 mm, please provide proof of last chest x-ray and treatment if applicable.

HEALTH CARE PROVIDER

Printed Name_____ Signature_____

Address_____ Phone (_____) _____

***STUDENT RELEASE*:** *I authorize Juniata College to release my immunization record upon my verbal request. I understand release of all other information contained in my medical record will require my written authorization.*

Student signature _____ *Date*_____

PHYSICIAN'S REPORT OF HEALTH EVALUATION

To the examining physician: Please review the student's history and complete the physician's report and immunization record.

STUDENT'S NAME: _____ DOB: _____

B/P _____/_____ Pulse _____reg _____irr Height _____ Weight _____

Vision R20/_____ L20/_____ Corrected R20/_____ L20/_____ Hearing R _____/_____ L_____/_____

		Normal	Abnormal	Explain:
1	HEENT			
2	Respiratory			
3	Cardiovascular			Murmur Y N
4	Skin			
5	Spine			
6	Lymphatics			
7	Thyroid			
8	Abdomen			
9	Extremities			
10	Psychiatric			
11	Neurologic			

General Health – please attach a separate sheet for the following questions if necessary:

Have you any general comments regarding the care of this client? _____

Is the student under treatment for any medical/emotional conditions? _____

Does the student have any significant medical history of which we should be aware? _____

Has the student ever had surgery? If yes, when and what? _____

Please furnish as much information as possible so that we may help you care for your patient while they are on campus. Also please note that the Health Center is closed during the summer and over school breaks.

Gynecological History

Menstruation age of onset: _____; lasts _____ days; regular ☐ every _____ days; irregular ☐

Pain: never ☐ sometimes ☐ always ☐ Usual treatment of pain _____

Date of physical exam: _____/_____/_____

_____ _____

Physician's Name (printed) Physician's signature

_____ _____

Address City / State / Zip

(_____) _____ (_____) _____

Phone Fax