



DIVISION OF STUDENT AFFAIRS
Counseling and Health Services

Student Health Center Health History Form 2009-10

STUDENT ID NUMBER: _____

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

CHECK ALL THAT APPLY: Undergraduate Graduate Resident Commuter International Transfer Transfer Junior Nursing

Health History Form Instructions

Required of all:

- undergraduate full-time students (residential and commuter)
- full-time residential graduate students
- full-time graduate students wishing to receive care at the Student Health Center

Return the completed health form:

- **Fall freshmen:** return the completed health form when attending Day ONE in June or July.
- **OR** mail completed form before July 10 to La Salle University, Student Health Center, 1900 W. Olney Ave., Box 419, Philadelphia, PA 19141
- **All others** not attending Day ONE please mail within 30 days to above address.

FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.

Physician to fill out this section of required vaccines

VACCINE	DATE
DPT SERIES (Date series completed):	
Td/TDAP/ADACEL (circle) (Booster in last 10 years):	
MMR (if born after 1956) Two doses OR +MMR IGG titer:	
MMR #1 (Measles, Mumps, Rubella):	
MMR #2 (Measles, Mumps, Rubella):	
or MMR IGG Titer (positive result):	
Hepatitis B #1:	
Hepatitis B #2:	
Hepatitis B #3:	
Chickenpox (if born after 1979 or <u>not born in USA</u>):	
If no disease (or <u>not born in USA</u>) then two doses of vaccine are required.	
Varivax vaccine #1:	
Varivax vaccine #2:	
If History of Disease —enter date; Varicella IGG titer is recommended for proof of immunity:	
Tuberculosis Testing (PPD) —Recommended for all students; only REQUIRED for students who:	
• Have lived in or visited South America, Central America, Asia, Eastern Europe, or Africa in the last five years.	
• Are education majors or entering the School of Nursing and Health Sciences.	
• Had contact with a known case.	
Country of Birth: _____	
Result: <input type="radio"/> negative <input type="radio"/> positive	
Induration _____ mm	
If required: Chest X-ray results	
International students—USA X-ray within last 3 months:	
<input type="radio"/> Normal <input type="radio"/> Abnormal	

LA SALLE UNIVERSITY REQUIRES ALL FULL-TIME RESIDENTIAL STUDENTS (GRADUATE AND UNDERGRADUATE) AND UNDERGRADUATE COMMUTER STUDENTS, TO RECEIVE THE VACCINE OR SIGN A WAIVER PER PENNSYLVANIA STATE LAW.

MENINGITIS WAIVER: READ ENCLOSED MENINGITIS FACT SHEET BEFORE MAKING DECISION.

MENINGOCOCCAL MENINGITIS VACCINE (A/C/Y/W-135): _____ Date

DECLINE: I have read the information about Meningococcal Meningitis vaccine; however, I decline the vaccine at this time. I understand that in declining this vaccine, I continue to be at risk for this serious disease. I understand that if I change my mind in the future and want the vaccine, I can receive it at the La Salle University Student Health Center at cost.

Student Signature Date

If student is under the age of 18, parental consent is necessary.

Parent Signature Date

Name of Health Care Provider

Address

City, State, and Zip

Phone

Signature of Provider

PLEASE INFORM PATIENT OF ANY IMMUNIZATION UPDATES NEEDED FOR COMPLETION OF REQUIREMENTS.

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

Students to fill out this information

STUDENT INFORMATION

SOCIAL SECURITY NUMBER: _____
STUDENT ID NUMBER: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____
CELL PHONE: _____
BIRTH DATE _____ SEX: MALE FEMALE
(month/day/year)
COUNTRY RAISED IN: _____
COUNTRY OF BIRTH: _____

FAMILY HISTORY

	AGE	OCCUPATION	HEALTH STATUS (EXCELLENT; GOOD; FAIR; POOR; IF DECEASED, LIST CAUSE OF DEATH)
FATHER	_____	_____	_____
MOTHER	_____	_____	_____
BROTHERS	_____	_____	_____
SISTERS	_____	_____	_____

PARENT OR OTHER TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
COUNTRY: _____ HOME PHONE NUMBER: _____
WORK PHONE NUMBER: _____ CELL PHONE NUMBER: _____

HEALTH INSURANCE—REQUIRED OF ALL STUDENTS

All students are required to carry health insurance.
It is recommended that all international students purchase a health insurance plan from the United States.
Insurance information will be mailed to you during the summer for those who wish to purchase the University sponsored insurance through First Student
INSURANCE COMPANY NAME: _____

which is underwritten by UnitedHealthcare Insurance Company. View their Web site at www.firstriskadvisors.com if interested.

All premiums should be sent directly to the health insurance company.

The University sponsored Health Insurance application is available at www.lasalle.edu/health.

ID NUMBER: _____ **GROUP NUMBER:** _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
PHONE NUMBER: _____
POLICY ISSUED TO: _____ RELATIONSHIP TO STUDENT: _____
ADDRESS: _____ PHONE NUMBER: _____
CITY: _____ STATE: _____ ZIP: _____
SOCIAL SECURITY NUMBER OF INSURED: _____ DATE STUDENT INSURED THROUGH: _____

PRESCRIPTION PLAN

COMPANY NAME: _____ PHONE NUMBER _____
PLAN NUMBER: _____ GROUP NUMBER _____

DENTAL PLAN

COMPANY NAME: _____ PHONE NUMBER _____
PLAN NUMBER: _____ GROUP NUMBER _____

PLEASE INFORM US OF ANY CHANGES. STUDENTS SHOULD CARRY A COPY OF ALL INSURANCE INFORMATION IN WALLET

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

Students to fill out this information

MEDICAL HISTORY: HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

A. DRUG ALLERGIES

- Penicillin or Ampicillin
- Sulfa
- Codeine
- Food Allergy, please specify: _____
- Other (describe): _____
- None

B. NEUROLOGICAL

- Concussion (number of times): _____
- Cerebral Palsy
- Dizziness/Fainting
- Migraines
- Seizure Disorders
- Other (describe): _____
- None

C. CARDIOVASCULAR

- Blood Disorder
- Heart Condition
- Elevated Blood Pressure
- Mitral Valve Prolapse
- Other (describe): _____
- None

D. GASTROINTESTINAL

- Chronic Inflammatory Bowel Disease
- Digestive Problems
- Ulcer Disease
- Other (describe): _____
- None

E. GENITOURINARY

- Urinary Tract Infections
- Kidney Stones
- Kidney Disease or Infections
- Other (describe): _____
- None

F. INFECTIOUS DISEASES

- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus) DATE: _____
- Positive TB testing DATE: _____
- Preventative INH Treatment for Tuberculosis DATE: _____
- HIV
- Other (describe): _____
- None

G. METABOLIC/ENDOCRINE

- Diabetes
- Thyroid Disorder
- Systemic Lupus Erythematosus
- Other (describe): _____
- None

H. RESPIRATORY

- Asthma
Asthma Medication: _____
- Allergies
Allergy Medication: _____
- Other (describe): _____
- None

I. PSYCHOLOGICAL OR SOCIAL

- Alcohol/Drug Abuse Problems
- Anxiety
- Depression
- Eating Disorder
- Panic Attack
- Insomnia
- ADD/ADHD
- Other (describe): _____
- None

J. WOMEN'S HEALTH

- Amenorrhea (no periods)
- Polycystic Ovaries
- Excessive Menstrual Cramps
- Other (describe): _____
- None

K. CANCER (describe): _____

- None

L. ILLNESSES NOT LISTED ABOVE: _____

M. SURGERIES AND HOSPITALIZATIONS

Dates _____ Specify reason: _____

N. CURRENT MEDICATIONS AND DOSAGES

NAME: _____ Start Term: _____ Date of Birth: _____
(Last) (First) (Middle) (month/year) (month/day/year)

Students to fill out this information

SPECIAL HEALTH REQUIREMENTS

Are you receiving care for a chronic condition or serious illness? yes no
If yes, a letter from your health-care provider with recommendations for care is suggested. Please send the letter to the Student Health Center.

PLEASE IDENTIFY ILLNESS OR CONDITION: _____

SPECIALIST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ DATE OF LAST VISIT: _____

PRIMARY HEALTH-CARE PROVIDER NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ FAX: _____

If you anticipate the need for local medical care while on campus, please contact the Student Health Center for referrals.

HOUSING ACCOMMODATIONS FOR HEALTH/MEDICAL CONCERNS

Download the Special Housing Accommodations form from the Student Health Center Web site at www.lasalle.edu/health. The application deadline for special housing accommodations is **June 1** and if approved you will be notified by Administrative Services. Air conditioning is not approved for allergies.

DISABILITY

Do you consider yourself as having a disability? yes no

Explanation of Disability: _____

If you require classroom accommodations for illness, injury, or disability condition, please contact Rose Lee Pauline in the Affirmative Action Office at 215.951.1014. For questions about parking accommodations, call the Parking Office at 215.951.1066.

PATIENT PRIVACY RIGHTS

All services provided by the Student Health Center are strictly confidential. Medical information cannot be released to family members without permission from the student unless the student is a threat to self or others. You can visit our Web site at www.lasalle.edu/health for more information about our services or call our office at 215.951.1565.

ABOUT THE STUDENT HEALTH CENTER

The Student Health Center is a primary health-care facility that provides free direct health-care services, while assisting students to take responsibility for their own health and wellness.

Hours: Monday through Friday, from 8:30 a.m. to 4 p.m., when classes are in session.

Address: Student Health Center, 1900 W. Olney Ave, Box 419, Philadelphia, PA 19141-1199

Web site: www.lasalle.edu/health

Phone: 215.951.1565

Fax: 215.951.1566

REMEMBER: FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.

FOR STUDENT HEALTH CENTER STAFF ONLY

CHART COMPLETE (DATE): _____

CHART MISSING THE FOLLOWING DATA: _____

All information on this form is **confidential**. It is solely for Student Health Center use and will not be released without the student's written consent.