



DIVISION OF STUDENT AFFAIRS  
Counseling and Health Services

# Student Health Center Health History Form 2011-12

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 Junior Nursing  Transfer Class \_\_\_\_\_

## Health History Form Instructions

### Required of all:

- full-time undergraduate students (residential and commuter)
- residential students (graduate or special programs)

### 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

|   |  |
|---|--|
| <b>DPT SERIES</b> (Date series completed): .....  |  |
| <b>Td/TDAP/ADACEL</b> (circle) (Booster in last 10 years): .....  |  |
| <b>MMR</b> (if born after 1956) Two doses <b>OR</b> +MMR IGG titer:<br><b>MMR #1</b> (Measles, Mumps, Rubella): .....                         |  |
| <b>MMR #2</b> (Measles, Mumps, Rubella): .....  |  |
| or <b>MMR IGG Titer</b> (positive result): .....  |  |
| <b>Hepatitis B #1:</b> .....  |  |
| <b>Hepatitis B #2:</b> .....  |  |
| <b>Hepatitis B #3:</b> .....  |  |
| <b>Chickenpox</b> (if born after 1979):<br><b>If no disease</b> , then two doses of vaccine are required.<br><b>Varivax vaccine #1:</b> ..... |  |
| <b>Varivax vaccine #2:</b> .....  |  |
| <b>If history of disease</b> —enter date; Varicella IGG titer is recommended for proof of immunity: .....                                     |  |
| <b>Tuberculosis Testing (PPD)</b> —Recommended for all students; only <b>REQUIRED</b> for students who: .....                                 |  |
| • Have lived in or visited South America, Central America, Asia, parts of Europe, or Africa in the last five years.                           |  |
| • 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:<br><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 MENINGITIS VACCINE OR SIGN A WAIVER PER PENNSYLVANIA STATE LAW.**

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

**MENINGOCOCCAL MENINGITIS VACCINE (A/C/Y/W-135):** \_\_\_\_\_  
Date  
 menomune  menactra  menveo

**DECLINE:** I have read the information about the 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 or parent signature if student is under the age of 18 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

STUDENT ID NUMBER: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
HOME PHONE NUMBER: \_\_\_\_\_  
STUDENT CELL PHONE NUMBER: \_\_\_\_\_  
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

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](http://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](http://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: \_\_\_\_\_  
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/Ampicillin/Amoxicillin
- Sulfa
- Codeine
- Food Allergy, please specify: \_\_\_\_\_
- Other (describe): \_\_\_\_\_
- None

**B. NEUROLOGICAL**

- Concussion (list dates): \_\_\_\_\_
- Cerebral Palsy
- Dizziness/Fainting
- Migraines
- Seizure Disorders
- Other (describe): \_\_\_\_\_
- None

**C. CARDIOVASCULAR**

- Fainting
- Blood Disorder
- Heart Condition (list): \_\_\_\_\_
- 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
- Other (describe): \_\_\_\_\_
- None

**F. INFECTIOUS DISEASES**

- Chicken Pox
- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus) DATE: \_\_\_\_\_
- Positive TB testing DATE: \_\_\_\_\_
- Preventative INH Treatment for Tuberculosis DATE: \_\_\_\_\_  
Length of Treatment: \_\_\_\_\_
- HIV
- Other (describe): \_\_\_\_\_
- None

**G. METABOLIC/ENDOCRINE**

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

**H. RESPIRATORY**

- Asthma/Sports-Induced Asthma  
Asthma Medication: \_\_\_\_\_
- Allergies: \_\_\_\_\_
- 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](http://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](http://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](http://www.lasalle.edu/health)

**Phone:** 215.951.1565

**Fax:** 215.951.1566

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

|   |
|---|
| <b>FOR STUDENT HEALTH CENTER STAFF ONLY</b> |
| 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.