LASALLE UNIVERSITY

DIVISION OF STUDENT AFFAIRS
Student Wellness Services

Student Health Center Health History Form **2019–20**

ABOUT THE STUDENT HEALTH CENTER

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

Hours: Monday through Friday, 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
Location: St. Benilde Tower, Suite 1026
Website: lasalle.edu/health **Email:** studenthealth@lasalle.edu
Phone: 215.951.1565 **Fax:** 215.951.1566

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 ❍ Transfer ❍ International ❍ ELI ❍ Veteran/Military

CLASS ❍ Freshman ❍ Sophomore ❍ Junior ❍ Senior

Completion required of new students in order to register for classes.

Due Aug. 30 for fall semester and Feb. 29 for spring semester.

Health care provider to fill out required vaccines or submit official copies of your vaccines

VACCINE	DATE
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):	
If history of disease—enter date; Varicella IgG titer is recommended for proof of immunity:	
If no disease, then two doses of vaccine are required.	
Varivax vaccine #1:	
Varivax vaccine #2:	

VACCINE	DATE
DPT SERIES (Date series completed):	
Td/TDAP/ADACEL (circle) (Booster in last 10 years):	
Tuberculosis Testing—Must be done in the USA, recommended for all students; only **REQUIRED for students who**:	
• Have lived in or visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa.	
• Had contact with a known case.	
Country of Birth: _____	
Country Raised in: _____	
• PPD—date/result/induration _____	
• T-Spot—date/result _____	
• QuantiFERON-TB Gold—date/result _____	
If required: USA Chest X-ray date/results _____	

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

MENINGOCOCCAL MENINGITIS VACCINE (A/C/Y/W-135)
Required by the State of Pennsylvania:

❍ **If initial dose given at under 16 years of age, two doses are required.**
❍ **If initial dose given at 16 years of age or older, one dose is required.**

VACCINE NAME DATE

1: _____

2: _____

❍ **DECLINE**: I have read the information about the Meningococcal Meningitis vaccine. I understand that in declining this vaccine, I continue to be at risk for this serious disease. I can always receive the vaccine at a future time.

_____
Student signature or parent signature if student is under the age of 18 Date

Information Regarding the Option to Decline the Meningitis Vaccine

Meningococcal disease is a serious bacterial illness of the brain and spinal cord. It is a leading cause of bacterial meningitis in children 2-18 years old in the United States. It can cause complications like loss of a limb, deafness, seizures, mental retardation and death. College freshman living in dormitories have an increased risk of getting meningococcal disease.

The best way to prevent the disease is through the Quadravalent (types A, C, W-135, Y) meningococcal vaccine. The State of PA requires college students to either obtain this vaccine or read this information and sign a waiver of refusal. Vaccines cannot prevent all types of this disease but it can significantly reduce your chances. If after reading about this disease you decide to decline it, you must sign the vaccine refusal line on page one of this health form.

There is an additional new meningitis vaccine for type B, which is recommended by the Center for Disease Control, but not required. Discuss this with your doctor. For more information on meningitis visit: cdc.gov/meningitis.

_____
Name of Health Care Provider Signature

_____
Address

_____
City, State, ZIP Phone

FOR STUDENT HEALTH CENTER STAFF ONLY

Complete date _____

Incomplete date _____

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	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

The following categories of students are required to carry health insurance either through the University-sponsored plan or through an alternative, comparable plan: all undergraduate day students, all resident students, all international students, all undergraduate evening students taking 12 or more credits, and all graduate students registered for six or more credits or in a full-time program.

Prior to first attendance at the University, and annually thereafter, students must complete the online student health insurance waiver/enrollment process. The deadline to opt out of the insurance premium is **Aug. 30, 2019** for the fall semester and **Feb. 29, 2020** for the spring semester.

Go to firststudent.com and select La Salle University, then click on either "waive insurance" or "enroll now." For customer service, call 800.505.4160.

PLEASE INFORM US OF ANY CHANGES.
STUDENTS SHOULD CARRY A COPY OF ALL INSURANCE INFORMATION AT ALL TIMES.

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 AND FOOD ALLERGIES

- ❍ Penicillin/Ampicillin/Amoxicillin
- ❍ Sulfa
- ❍ Codeine
- ❍ Food Allergy (please specify): _____
- ❍ Other (describe): _____
- ❍ **None**

B. NEUROLOGICAL

- ❍ Concussion (list dates): _____
- ❍ Cerebral Palsy
- ❍ Migraines
- ❍ Seizure Disorders Date of last seizure: _____
- ❍ Other (describe): _____
- ❍ **None**

C. CARDIOVASCULAR

- ❍ Fainting
- ❍ Blood Disorder
- ❍ Heart Condition (list): _____
- ❍ Elevated Blood Pressure
- ❍ Heart Murmur
- ❍ Other (describe): _____
- ❍ **None**

D. GASTROINTESTINAL

- ❍ Chronic Inflammatory Bowel Disease
- ❍ Digestive Problems (describe): _____
- ❍ Acid Reflux
- ❍ 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
- ❍ Other (describe): _____
- ❍ **None**

H. RESPIRATORY

- ❍ Asthma/Sports-Induced Asthma
  Asthma Medication: _____
- ❍ Seasonal Allergies: _____
- ❍ Other (describe): _____
- ❍ **None**

I. DERMATOLOGY

- ❍ Eczema
- ❍ Urticaria
- ❍ Psoriasis
- ❍ Other (describe): _____
- ❍ **None**

J. PSYCHOLOGICAL OR SOCIAL

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

K. WOMEN'S HEALTH (describe): _____

- ❍ **None**

L. CANCER (describe): _____

- ❍ **None** ❍ **Chemotherapy** ❍ **Radiation**

M. SURGERIES AND HOSPITALIZATIONS

Dates: Specify reason:

_____

_____

_____

N. CHRONIC, SERIOUS, OR OTHER ILLNESS

_____

_____

_____

O. 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 no, then this section is complete. 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: _____

_____

PRIMARY HEALTH CARE PROVIDER NAME: _____

_____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ FAX: _____

SPECIALIST NAME: _____

ADDRESS: _____

_____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____ DATE OF LAST VISIT: _____

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

CLASSROOM ACCOMMODATIONS

If you want to request classroom accommodations, you must contact: Rose Lee Pauline, Affirmative Action Office, at pauline@lasalle.edu or 215.951.1014

PARKING ACCOMMODATIONS

For parking accommodations, you must 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 others.

You can visit our website at lasalle.edu/health for more information about our services, or call our office at 215.951.1565.

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

3805-0419