

Student Name: _____

YCP ID # _____

Are you currently taking any medication: Yes No

If so, specify _____

Surgical Operations (please list) _____

Have you been treated for an emotional or psychological disorder? Yes No

Diagnosis or Condition: _____ Date: _____

Counseling at present? Yes No

Psychologist/Psychiatrist Name _____ Phone Number _____

HEALTH AND ACCIDENT INSURANCE DATA

All health and accident insurance data must be completed.

Family Policy Information

Insurance Company Name _____

Name of Insured _____

Member ID # _____ Group # _____

Insurance Address _____

Student's Relationship to Insured: _____ Self _____ Spouse _____ Dependent

Employer Name/Employer # _____

Insured's SSN # _____ Insured's D.O.B. _____

Prescription Drug Coverage _____ Yes _____ No

If yes, complete: Plan Name _____ Plan ID# _____

Choose one of the following required laboratories for use during student's college career:

Wellspace Quest Lab Corp (You may check with your insurance carrier to determine a participating laboratory from those listed)

You must include a copy of the FRONT and BACK of your insurance cards

MEDICAL CONSENT

Please read carefully and sign. I/We hereby grant permission to the medical team of the Student Health Services or their consulting physician/nurse practitioner to render to my son or daughter (or myself if over 18 years of age) emergency treatment or other medical or surgical care that might be deemed necessary to the health and well-being of the student. Also, when necessary for executing such care, I/we grant permission for hospitalization.

Signatures: _____

Parent or Guardian

Date

Student

Date

Student Name: _____ YCP ID # _____

IMMUNIZATION HISTORY

VACCINE

MMR		
Required: 2 doses or Titer		
Mo	Day	Year

OR

Measles		
Required: 2 doses or Titer		
Mo	Day	Year
Titer - attach copy		
Date		
Results		

Mumps		
Required: 2 doses or Titer		
Mo	Day	Year
Titer - attach copy		
Date		
Results		

Rubella		
Required: 2 doses or Titer		
Mo	Day	Year
Titer - attach copy		
Date		
Results		

Td or Tdap (circle one)		
Required within last 10 yrs.		
Mo	Day	Year

Varicella		
Required: 2 doses or Titer		
Mo	Day	Year
Titer - attach copy		
Date		
Results		

Varicella (continued)		
US born	Yes	No
Born before 1980	Yes	No
Allied Health Professional/Health Care Field	Yes	No
Date of Physician diagnosed disease		
Physician Signature:		

Hepatitis B		
3 doses recommended		
Mo	Day	Year

Meningococcal		
Required: VAC or Waiver		
Mo	Day	Year

Hepatitis A		
2 doses recommended		
Mo	Day	Year

OPV/IPV		
Required		
3 dose primary series		
Mo	Day	Year

HPV (Females only)		
3 doses recommended		
Mo	Day	Year

Flu Recommended		
Mo	Day	Year

Tuberculin Screening Information (Required)		
Note: This must be a current screening. Dates older than one year will not be accepted.		
Date Applied _____	Date Read* _____	Result in millimeters _____
<i>If results 10 millimeters or greater, attach copy of chest x-ray report.</i>		
Please note if patient referred to local health department for treatment/follow-up Yes No		
*Must be within 48-72 hours or test considered invalid		

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Student Name: _____ YCP ID # _____

PHYSICAL EXAMINATION

Date: _____

BP _____ Height _____ Weight _____

	Normal	Abnormal	Comments
Eyes/Vision			
HEENT/Hearing			
Chest/Lungs			
Heart/Murmur			
Abd/GU/Gyn			
Extremities/Neuro			
Skin/Lymphatic			
Emotional/ Psychiatric			

Do you advise any restriction in the following? If so, please explain below under remarks.

	No	Yes
Physical Education	_____	_____
Intercollegiate Sports	_____	_____
Intramural Sports	_____	_____

Remarks and Recommendations of Provider:

Please note any condition, emotional or physical, plus medications that we should be aware of for continuity of care purposes.

Provider Signature _____ MD/DO/CRNP/PA

Printed Name _____

Street _____ City _____ State _____ Zip _____

Phone Number _____

FAX Number _____