

# YORK COLLEGE STUDENT HEALTH AND MEDICAL RECORD

INSTRUCTIONS –COMPLETE AND RETURN TO: DEPT. OF NURSING, YORK COLLEGE OF PENNSYLVANIA, YORK, PA 17405-7199

This form, when completed by you and your health care provider, will provide a record of your required health examination. Please print in ink or type. Unanswered questions will be returned for completion, thus, to avoid delay in processing, please do not omit any portion of either side of this form. You should make a copy of this completed form to keep with your personal records.

Student Name \_\_\_\_\_  
 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Phone Number (\_\_\_\_\_) \_\_\_\_\_  
 Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_

Parent/Guardian/Emergency Contact \_\_\_\_\_  
 Relationship to Student \_\_\_\_\_  
 Address \_\_\_\_\_  
 Home Phone Number (\_\_\_\_\_) \_\_\_\_\_  
 Work Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

## PERSONAL HISTORY

Social Security Number \_\_\_\_\_ YCP Student ID Number \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Gender \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
 Religion \_\_\_\_\_ Marital Status \_\_\_\_\_

Surgical Operations (please list) \_\_\_\_\_  
 Are you currently taking any medication: \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If so, specify \_\_\_\_\_

Please indicate date or age you have had or do have now any of the following:  
 Measles  Rheumatic Fever  
 Mumps  Asthma  
 Scarlet Fever  Migraine (Headache)  
 Whooping Cough  Seizures or Convulsions  
 Pneumonia  Frequent Colds  
 Chicken Pox  Diabetes  
 Poliomyelitis  Hepatitis  
 Mononucleosis  Other (specify) \_\_\_\_\_

Do you wear glasses? \_\_\_\_\_ Contact Lenses? \_\_\_\_\_  
 Do you have any of the following allergies:  
 Penicillin  Other Antibiotics (specify) \_\_\_\_\_  
 Hay Fever  Latex  
 Eczema  Insect Bite  
 Food  Vaccines \_\_\_\_\_  
 Chemicals  Other (specify) \_\_\_\_\_  
 Have you been treated for an emotional or psychological disorder? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Complete one of the following options regarding health and accident insurance: Include copy of front and back of insurance cards**

I am covered under a family policy. Insurance Company Name \_\_\_\_\_ Name of Insured \_\_\_\_\_  
 Member ID # \_\_\_\_\_ Group # \_\_\_\_\_ Student's Relationship to Insured: \_\_\_Self \_\_\_Spouse \_\_\_Dependent  
 Insurance Address \_\_\_\_\_

I will purchase the College policy. Employer Name/Employer # \_\_\_\_\_ Insured's SSN # \_\_\_\_\_ Insured's D.O.B. \_\_\_\_\_  
 Prescription Drug Coverage \_\_\_\_\_ Yes \_\_\_\_\_ No If Yes, complete: Plan Name \_\_\_\_\_ Plan ID# \_\_\_\_\_

## MEDICAL CONSENT

Please read carefully and sign. I hereby grant permission to the medical team of the Student Health Services or their consulting physician 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 grant permission for hospitalization.

Signatures: \_\_\_\_\_  
 \_\_\_\_\_ Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_ Student \_\_\_\_\_ Date \_\_\_\_\_

**PHYSICAL EXAMINATION**

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

BP \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

	Normal	Abnormal	Comments
Eyes/Vision	_____	_____	_____
HEENT/Hearing	_____	_____	_____
Chest/Lungs	_____	_____	_____
Heart/Murmur	_____	_____	_____
Abd/GU/Gyn	_____	_____	_____
Extremities/Neuro	_____	_____	_____
Skin/Lymphatics	_____	_____	_____
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.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATION HISTORY** All information must be completed or enclosed on separate form

Vaccine	Date	Date	Date	Date	Date
DTP/DT/DTaP/Td/Tdap (Basic series and booster within the last 10 yrs required. Tdap preferred)					
OPV/IPV (primary series required)					
Hepatitis B ( 3 doses or positive anti-HBs required)					
Meningococcal Vaccine (required) --or-- (waiver)					
Varicella Vaccine (2 doses required)--or-- (titer)--or--(date of physician-diagnosed disease)					
MMR (2 doses required on or after 1 <sup>st</sup> birthday)					
<b>--OR--</b>					
Measles (2 doses required on or after 1 <sup>st</sup> birthday) --or-- (titer)					
Mumps (2 doses required on or after 1 <sup>st</sup> birthday) --or-- (titer)					
Rubella (2 doses required on or after 1 <sup>st</sup> birthday) --or-- (titer)					
Influenza Vaccine (recommended annually)					

\*\*Please indicate date and result of any titers or attach copies\*\*

Tuberculin Screening Information (PPD Required)		
Note: This must be a current screening, within 6 months of beginning clinical courses. Older dates will not be accepted.		
Date Applied _____	Date Read _____	Result _____
<i>If positive, attach copy of chest x-ray report.</i>		

Provider Signature \_\_\_\_\_ MD/DO/CRNP/PA

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

FAX Number \_\_\_\_\_