YCP ID: _____ - _____ - _____

YORK COLLEGE
OF PENNSYLVANIA

HEALTH REQUIREMENTS FOR INTERNATIONAL STUDENTS

OFFICE OF HEALTH SERVICES

York PA 17403-3651

(717) 849-1615 Fax: (717) 849-1601 email: healthcenter@ycp.edu

DEADLINES: Fall: June 15; Spring: January 15

(Forms must be complete prior to attending classes and/or residing in the residence halls.)

Name_____ DOB _____/_____/_____
LAST FIRST MI

Home Address: Street_____ City: _____ State: ___Zip:_____

Student Cell Phone_____ Home Phone_____

Name of Parent/Guardian (Emergency Contact) _____ Relationship_____

Contact Phone Number_____

Insurance Information:

International students on F-1 visas are automatically enrolled in the Accident & Sickness Insurance plan offered by the college as minimum coverage. However, additional health coverage is recommended.

PERMISSION FOR TREATMENT

I hereby grant permission to York College, or its authorized providers, which may include student nurses, nurse practitioner students, physician assistant students, medical students, residents, as well as nurse practitioners and physicians, to furnish such medical care as my son/daughter/self may require, including examination, treatment, immunizations, etc. This permission is conditioned upon the understanding that in the event of serious illness or the need for hospitalization and/or major surgery, the College will use all reasonable efforts to contact my emergency contact. Failure in such efforts, however, should not prevent the College from providing such emergency treatment and exchange of records as may be necessary by an off-site provider.

We ask that the student verify with their parents, and/or with their insurance company, participating hospitals, laboratories, and physicians in the York College area in case treatment and/or service are needed outside of YCP Health Services.

If this information is not known at the time of visit or unable to be obtained, we will send the student to the nearest facility located to YCP.

In the event that payment for services by an outside provider is denied by your insurance company, we ask that the student or guarantor accept financial responsibility and not hold YCP Health Services responsible for expenses incurred under these conditions.

Having read the above statements signifies that I understand the contents and agree to be responsible for this information and any expenses incurred.

Signature_____ Date _____/_____/_____

NOTE: Parent or legal guardian must sign if the student is under 18 years of age.

YCP ID: _____ - _____ - _____

MEDICAL HISTORY

PLEASE COMPLETE THIS BEFORE GOING TO YOUR HEALTHCARE PROVIDER FOR EXAMINATION

1. List any illness or medical condition for which you are being treated currently.
   Condition Year Diagnosed Treatment

_____

_____

2. List any operations or hospitalizations you have had.

_____

_____

3. List all medications you are now taking (including over-the-counter, supplements, birth control pills, allergy serum, psychotropics)
   Name of Medication Dose How Often

_____

_____

_____

4. List your **ALLERGIES** to:_____ Reaction: _____
   Medications:_____
   Environment/Food/Insects:_____

MEDICAL HISTORY: Check all applicable items, whether current or past. Give details in the space provided below.

____Congenital defects
____Frequent sore throats
____Sinusitis
____Frequent ear infections
____Hearing defects
____Serious eye defects
____Bronchitis
____Asthma
____Pneumonia
____Heart defects
____Rheumatic fever
____Irritable bowel syndrome
____Ulcer disease
____Inflammatory bowel disease
____Seizure disorder
____Fainting
____Neurologic disorder
____Headaches
____Arthritis
____Orthopedic infections
____Urinary tract infections
____Diabetes mellitus
____Endocrine problem
____Smoker
____Drug problem
____Alcohol problem
____Learning disability/ADD
____Mononucleosis
____Chickenpox
____Treatment by psychologist, psychiatrist, or counselor
____Menstrual disorder
____Skin disorder
____Eating disorder
____Concussion
____Other

Please provide details of above items checked:

_____

_____

FAMILY HISTORY

Have any of your relatives had any of the following:

	Yes	No	Relationship
Cancer			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Kidney Disease			
Lung Disease			
Tuberculosis			
Ulcer Disease			

YCP ID: _____ - _____ - _____

PHYSICAL EXAMINATION (NCAA ATHLETES: No sooner than April 15)

Date of Exam:_____

Height_____ Weight_____lbs. BP _____/_____ Pulse_____

	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	_____	_____
NCAA Athletics ***(*See below)***	_____	_____
Intramural Athletics	_____	_____

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.

_____

_____

****REQUIRED for participation in NCAA Athletics:***

Sickle cell trait testing results (please research birth screening results) must be obtained and submitted to YCP Health Services.

Please check one: Sickle cell trait (+) ____ Sickle cell trait (-) ____

Provider Signature: _____MD/DO/CRNP/PA

Printed Name_____ Date: _____

Address_____

Phone Number: _____ Fax Number:_____

YCP ID: _____ - _____ - _____

IMMUNIZATION RECORD

TITERS ARE REQUIRED FOR ALL INTERNATIONAL STUDENTS. OFFICIAL DOCUMENTATION MUST BE PROVIDED IN ORDER TO BE COMPLIANT. (IMMUNIZATIONS ARE REQUIRED IF TITERS DO NOT SHOW IMMUNITY TO THE DISEASE.)

Measles
Mumps
Rubella

Varicella

Hepatitis B

A Quanti-FERON Test is required to rule out latent tuberculosis infection:

Quanti-FERON Test Results: Positive ( ) Negative ( )

The following immunizations are required:

Tetanus/Diphtheria/Pertussis (within the last ten years) _____/_____/_____

Meningococcal – quadrivalent vaccine – 2 doses if first dose was given prior to age 16 – 1 dose if given after age 16
#1 _____/_____/_____ #2 _____/_____/_____

NOTE: Please read meningitis information on the Centers for Disease Control website under https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html.

(WAIVER for Meningococcal vaccine: I have read and understand the information you provided about the risks of meningococcal disease and the availability and effectiveness of the vaccine, but for religious or other reasons, I decline the meningococcal vaccine at this time.)

Signature (student)_____Date_____

Parent (if student under age 18)_____Date_____

Provider Signature:_____MD/DO/CRNP/PA