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.
1. List any illness or medical condition for which you are being treated currently.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Year Diagnosed</th>
<th>Treatment</th>
</tr>
</thead>
</table>

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)

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>How Often</th>
</tr>
</thead>
</table>

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
- Heart defects
- Arthritis
- Mononucleosis
- Frequent sore throats
- Rheumatic fever
- Orthopedic infections
- Chickenpox
- Sinusitis
- Irritable bowel syndrome
- Urinary tract infections
- Treatment by
- Frequent ear infections
- Ulcer disease
- Diabetes mellitus
- Psychologist, psychiatrist, or counselor
- Hearing defects
- Inflammatory bowel disease
- Endocrine problem
- Menstrual disorder
- Serious eye defects
- Seizure disorder
- Smoker
- Skin disorder
- Bronchitis
- Fainting
- Drug problem
- Eating disorder
- Asthma
- Neurologic disorder
- Alcohol problem
- Concussion
- Pneumonia
- Headaches
- Learning disability/ADD
- Concussion

Please provide details of above items checked:

_________________________________________________________________________________________________

_________________________________________________________________________________________________

FAMILY HISTORY

Have any of your relatives had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
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<td></td>
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<tr>
<td>High Cholesterol</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
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<td></td>
<td></td>
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<tr>
<td>Kidney Disease</td>
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<tr>
<td>Lung Disease</td>
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<td></td>
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<tr>
<td>Tuberculosis</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ulcer Disease</td>
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</tbody>
</table>
**PHYSICAL EXAMINATION**

(NCAA ATHLETES: No sooner than April 15)

Date of Exam:____________

Height___________ Weight___________lbs. BP ______/______ Pulse___________

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT/Hearing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest/Lungs</td>
<td></td>
<td></td>
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<tr>
<td>Heart/Murmur</td>
<td></td>
<td></td>
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<tr>
<td>Abd/GU/Gyn</td>
<td></td>
<td></td>
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<tr>
<td>Extremities/Neuro</td>
<td></td>
<td></td>
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<tr>
<td>Skin/Lymphatic</td>
<td></td>
<td></td>
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<tr>
<td>Emotional/Psychiatric</td>
<td></td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NCAA Athletics</strong> (*See below)</td>
<td></td>
<td></td>
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<tr>
<td>Intramural Athletics</td>
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</tbody>
</table>

**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:_____________________________
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