OFFICE OF HEALTH SERVICES

York College of PA
York PA 17403-3651
(717) 849-1615 Fax: (717) 849-1601 email: healthcenter@ycp.edu

DEADLINES: Fall admit: June 15; Spring admit: November 15

Date of Entrance: (circle one) Fall Spring 20____

Name_____ DOB _____/_____/_____
LAST FIRST MI

Gender ☐ M ☐ F ☐ T Social Security #_____ YCP ID # ____ - ____ - ____

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

Student Cell Phone_____

Name of Parent/Guardian(Emergency Contact)_____ Relationship_____

Home Phone _____Work Phone_____Mobile Phone_____

Insurance Information: All students are required to have health insurance

Insurance Company Name_____ Policy Holder_____

Policy or ID #_____ Group # _____

Prescription Plan ☐ Y ☐ N

Circle the laboratory covered by your insurance carrier: LabCorp Quest WellSpan

PLEASE ENCLOSE A COPY OF *FRONT* AND *BACK* OF INSURANCE CARD.

PERMISSION FOR TREATMENT

I hereby grant permission to York College, or its authorized providers, which may include student nurses, nurse practitioner 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.

Signature_____ Date _____/_____/_____

NOTE: Parent or legal guardian must sign if the student is under 18 years of age.
Religious Preference (optional)_____

----------Student Health Office Use Only----------

Incomplete For: (circle) MMR: 1 2 Tdap or Td Varicella: 1 2 PPD PE MCV: V or W
Hep B: 1 2 3 Polio:

Insurance Complete: Y N

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	____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,
____Hearing defects	____Inflammatory bowel disease	____Endocrine problem	or counselor
____Serious eye defects	____Seizure disorder	____Smoker	____Menstrual disorder
____Bronchitis	____Fainting	____Drug problem	____Skin disorder
____Asthma	____Neurologic disorder	____Alcohol problem	____Eating disorder
____Pneumonia	____Headaches	____Learning disability/ADD	____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: _____ - _____ - _____

Student's last name First name MI

PHYSICAL EXAMINATION (Within 6 months of entrance for athletes)

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 toYCP 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: _____ - _____ - _____

Student's last name First name MI

IMMUNIZATION RECORD

To Be Completed by Physician/NP/PA: _____*(provider signature)*

1. **MMR #1** Date: ____/____/____ **MMR #2** Date:____/____/____ (Dose 1 at 12 months or after, dose 2 at least 28 days after dose 1)
   Or, Rubeola Titer: ☐POS ☐NEG ***Rubella Titer***: ☐POS ☐NEG ***Mumps Titer***: ☐POS ☐NEG
   Date of Titer:____/____/____ Date of Titer:____/____/____ Date of Titer: ____/____/____

2. **Varicella (Chicken pox) Date of Disease: ___/___/___ , *OR***
   Immunization: **Two Doses Required: DOSE #1** Date: ____/____/____ **DOSE #2** Date: ____/____/____ , ***OR***
   Varicella titer: ☐POS ☐NEG
   Date of titer: ____/____/____

3. **Tdap required** Date: ____/____/____**(within the last 10 years)**

4. **Hepatitis B: (3 doses required)**
   Dose #1: Date: ___/___/___ **DOSE #2** Date: ___/___/___ **DOSE #3** Date: ___/___/___
   Or, Result of Hepatitis B Surface Antibody titer: ☐ POS ☐NEG

----------ATTENTION PROVIDERS----------

5. **Tuberculin Screening Information by Mantoux Skin Test *REQUIRED***
   (*Dates older than one (1) year will NOT be accepted.)*
   Date Applied:___/___/___ Date Read*: ___/___/___ Results in millimeters: _____

   If results 10 millimeters or greater, attach copy of chest x-ray report.
   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.***

6. **This section MUST BE COMPLETED BY ALL STUDENTS:**

MENINGITIS Immunization Information

Date of most recent immunization:

_____

♦(Refer to enclosed Meningitis fact sheet)

OR

Waiver:

I have received and reviewed the enclosed information regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I knowingly decline not to receive the vaccine at this time.

_____ _____
Signature of Student **Date**

_____ YCP ID: _____ - _____ - _____
Student's last name First name MI