 Student Name: _____YCP ID#: _____ / _____ / _____

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 Semester JUNE 15 Spring Semester 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:

Insurance Company Name_____ Policy Holder_____

Policy or ID #_____ Group # _____

Preferred lab for your insurance: _____

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, 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.

 Student Name: _____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	____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			

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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:_____

 Student Name: _____YCP ID#: _____ / _____ / _____

IMMUNIZATION RECORD

REQUIRED IMMUNIZATIONS OF ALL YORK COLLEGE STUDENTS:

The following vaccines require official proof of vaccine (medical documentation) *OR* blood test showing immunity.

Measles, Mumps, Rubella (MMR) – 2 verified doses or titers demonstrating immunity.

#1 _____/_____/_____ #2 _____/_____/_____
OR . . . .Blood test confirming immunity **(attach copy of lab results)**

Varicella (Chicken Pox) – 2 verified doses or titers demonstrating immunity.

#1 _____/_____/_____ #2 _____/_____/_____/
OR . . . .Blood test confirming immunity **(attach copy of lab results)**

Hepatitis B – 3 dose vaccine or titers demonstrating immunity

#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____
OR . . . .Blood test confirming immunity **(attach copy of lab results)**

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

COVID-19 - 2 doses or titers demonstrating immunity (*recommended*)

#1 _____/_____/_____ #2 _____/_____/_____
OR . . . .Blood test confirming immunity **(attach copy of lab results)**

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

 Student Name: _____YCP ID#: _____ / _____ / _____

Part I. Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran (Islamic Republic of)
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

***PLEASE ANSWER THE FOLLOWING QUESTIONS*:**

Have you ever had close contact with persons known or suspected to have active TB disease?	❑ Yes	❑ No
Were you born in one of the countries or territories listed above that have a high incidence of active TB disease? (If yes, please CIRCLE the country, above)	❑ Yes	❑ No
Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CIRCLE the countries or territories above)	❑ Yes	❑ No
Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	❑ Yes	❑ No
Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	❑ Yes	❑ No
Have you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?	❑ Yes	❑ No

If the answer is YES to any of the above questions, York College of Pennsylvania requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

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Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to ***any*** of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) ***or*** Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes_____No _____**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes_____No _____**

Tuberculin Skin Test : Date placed_____Date read_____Results_____mm

**Interpretation: positive____negative____

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

****Interpretation guidelines**

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

If tuberculin skin test is POSITIVE, a Quanti-FERON Test is required to rule out latent tuberculosis infection:

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

INH Treatment: Initiate Date_____X_____months Declined ( )

Provider Signature:_____MD/DO/CRNP/PA