NAME: _____ DATE OF BIRTH: ____/___/____

DUE: ____July 1, 2022_____

HEALTH EVALUATION

STUDENT HEALTH CENTER

INCOMING STUDENT: This form is to be completed prior to your arrival on campus. It requires a brief health history, insurance documentation, a physical examination and a record of your immunizations. To assure that your records are received and reviewed prior to your arrival, please return your completed form no later than July 1, 2022 to Saint Joseph's University, Student Health Center, Quirk Hall, 5600 City Avenue, Philadelphia, PA 19131. If you have any questions please call (610) 660-1175. This information is strictly for the use of the Health Center and will not be released to anyone without your knowledge and consent.

PLEASE RETAIN A COPY OF THIS FORM BEFORE SUBMITTING.

FAILURE TO COMPLY WILL RESULT IN A MEDICAL HOLD, PREVENTING REGISTRATION.

_____ _____

LAST NAME (PRINT) FIRST NAME MIDDLE GENDER

_____ _____ 10_____ _____

(DATE OF BIRTH) STUDENT'S CELL PHONE SJU ID# PREFERRED NAME

CHECK ALL THAT APPLY: __Undergraduate __Graduate __Campus Housing __Commuter __International __Transfer

_____

HOME ADDRESS (number and street) CITY OR TOWN STATE ZIP CODE HOME PHONE

_____

EMERGENCY CONTACT NAME (relationship) PHONE

ACCIDENT AND/OR HEALTH INSURANCE

(Attach copy of card front and back)

Primary Insurance Company Name_____

Member ID#_____Group #_____

Insurance Address_____

City_____State_____Zip Code_____

Member Customer Service Phone Number_____

Student Relationship to Insured ₀Self ₀Spouse ₀Dependent

Name of Policy Holder_____ Policy Holders Date of Birth_____

Policy Holder's Signature_____ Referral required?_____

If Laboratory testing is needed, please indicate which lab your insurance requires Quest_____ Lab Corp_____

Saint Joseph's University requires all full-time undergraduate and all international students to show proof of health insurance coverage. Students are required to complete an on-line waiver or enrollment form. For more information visit www.firststudent.com.

CONSENT FOR TREATMENT (required for students under 18): CONSENT FOR TREATMENT (students over 18):

I hereby give consent for my minor child, _____ In the event of an Emergency, I hereby give permission to the to receive routine care through the SJU Health Center and its SJU Health Center and its affiliated hospital to secure for me affiliated hospital to secure for this child appropriate treatment. appropriate treatment.

Signature of Parent or Guardian _____Print Name of Parent or Guardian_____

Signature of Student_____

NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers					
Sisters					

HAVE ANY OF YOUR RELATIVES EVER HAD ANY OF THE FOLLOWING?

	YES	NO	RELATIONSHIP
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

MEDICAL HISTORY (To be completed by student)

PLEASE CHECK BELOW IF YOU HAVE HAD OR ARE CURRENTLY UNDER TREATMENT FOR ANY OF THE FOLLOWING

(Please explain all check marks in section below)

- ☐ Allergies (please specify)
  - ☐ Medications_____
  - ☐ Food_____
- ☐ German Measles (Rubella)
- ☐ Measles
- ☐ Mumps
- ☐ Infection Mononucleosis
- ☐ Scarlet Fever
- ☐ Anemia
- ☐ Thyroid Disorder
- ☐ Diabetes Mellitus
- ☐ Cancer
- ☐ Asthma
- ☐ Exercise-induced Asthma
- ☐ Shortness of Breath w/ Exercise
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Recurrent Bronchitis
- ☐ Recurrent Ear Infection
- ☐ Cardiac:
  - ☐ Marfan's Syndrome
  - ☐ Congenital Condition
  - ☐ Murmur
  - ☐ Rheumatic Heart Disease
  - ☐ High Blood Pressure
  - ☐ Heart Palpitations
  - ☐ Chest pain or Pressure
  - ☐ High Cholesterol
  - ☐ Other: Specify_____
- ☐ Disability:
  - ☐ Vision
  - ☐ Hearing
  - ☐ Locomotion
  - ☐ Other Motion
  - ☐ Learning
  - ☐ Emotional
  - ☐ Autism Spectrum
  - ☐ Other, explain_____
    _____
- ☐ Emotional Disorder:
  - ☐ Eating Disorder
  - ☐ Drug/Alcohol Dependency/Abuse
  - ☐ Depression
  - ☐ Panic/AnxietyDisorder
  - ☐ Bipolar Disorder
  - ☐ Mood Disorder
  - ☐ Obsessive Compulsive Disorder
  - ☐ Thoughts of hurting oneself
  - ☐ Hospitalized for Emotional Disorder
  - ☐ Other, explain_____
- ☐ Trouble sleeping
- ☐ Bone Fractures
- ☐ Joint Injury
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Back Pain/Problems
- ☐ Osgood-Schlatter
- ☐ Other Musculoskeletal Disorders
- ☐ Neurological Disorders
- ☐ Head Injury w/ loss of Consciousness
- ☐ Concussion
- ☐ Fainting/Dizziness
- ☐ Seizure Disorder
- ☐ Recurrent Sinusitis
- ☐ Recurrent Nosebleeds
- ☐ Vision Problems
- ☐ Hearing Loss
- ☐ Speech Detects
- ☐ Migraine Headaches
- ☐ Syncope or Fainting w/ Exercise
- ☐ Tension Headaches
- ☐ Ulcer
- ☐ Inflammatory Bowel Syndrome
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Pancreatitis
- ☐ Gallbladder Problems
- ☐ Reflux
- ☐ Rectal Bleeding
- ☐ Hernia
- ☐ Recurrent Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Chronic Kidney Disease
- ☐ Sexually Transmitted Disease
- ☐ Pelvic/Vaginal Infections
- ☐ Testicular Lump
- ☐ Testicular Torsion
- ☐ Menstrual History
  - ☐ Painful periods
  - ☐ Heavy flow
  - ☐ Irregular periods
  - ☐ Age of 1st period_____
- ☐ Pregnancy
- ☐ Eczema
- ☐ Hives
- ☐ Acne
- ☐ Chronic rash
- ☐ Heat Related Illness
- ☐ Serious Accident/Injury
- ☐ Surgeries
  - ☐ Tonsillectomy
  - ☐ Adenoidectomy
  - ☐ Other, explain_____
    _____

Do you use tobacco?
___Yes ___No ___pks/day

Do you drink alcohol?
___Yes ___No ___amt./week

Explanation for any positive answers:_____
_____
_____
_____
_____
_____

NAME: _____ DATE OF BIRTH: _____

PHYSICAL EXAMINATION (within one year)

To be completed by a healthcare provider: Please review the student's history and complete this form. Please comment on all positive answers. The information supplied will be used only as a background for providing health care. If this is necessary. This information is strictly for the use of the Student Health Center and will not be released without student consent.

BP / HEIGHT _____ inches WEIGHT _____lbs. VISUAL ACUITY: Right 20/ _____ Left 20/_____

Mediation Allergies: _____

Current Medications: _____

_____

_____

CLINICAL EVALUATION

	NORMAL	ABNORMAL	COMMENTS
1. SKIN			
2. HEAD, EARS, EYES, NOSE, THROAT			
3. MOUTH, TEETH, GUMS			
4. NECK AND THYROID			
5. LUNGS/CHEST			
6. BREASTS			
7. HEART			
8. ABDOMEN			
9. GENITALIA			
10. BACK/SPINE			
11. EXTREMITIES/MUSCULOSKELETAL			
12. NEUROLOGIC			
13. EMOTIONAL/PSYCHOLOGICAL			
14. OTHER FINDINGS			

Recommendation for physical activities, including participation in club, intramural & intercollegiate sports:

□ Unlimited □ Limited If Limited, please explain: _____

This student is able to meet the physical and emotional demands of college life:

□ Yes □ No If No, please explain: _____

Signature of Healthcare Provider _____Healthcare Provider Stamp_____Date _____

Print name of Healthcare Provider_____ Address_____Telephone _____Fax_____

NAME: _____ DATE OF BIRTH: _____

IMMUNIZATION RECORD

-TO BE COMPLETED BY HEALTHCARE PROVIDER –

REQUIRED IMMUNIZATIONS

1. COVID-19 VACCINE: Date 1: ___/___/___ BRAND: Moderna__ Pfizer__ Astra Zeneca__
   Date 2: ___/___/___ Johnson & Johnson__ Other_____

   COVID BOOSTER: Date 1: ___/___/___ BRAND: Moderna___ Pfizer___ Astra Zeneca___ J&J___

2. MMR (measles, mumps, and rubella): Date 1: ___/___/___
   Immunization with two doses of MMR, given on or after the first birthday and separated by at least one month. Date 2: ___/___/___
   Positive antibody titer (IGg) proving immunity is required for students in Clinical Profession Programs.
   Attach lab results.

3. TETANUS/DIPHTHERIA/PERTUSSIS: Date 1: ___/___/___
   Three doses of tetanus/diphtheria/pertussis are required with a booster given within the past ten years. Date 2: ___/___/___
   Date 3: ___/___/___
   Tdap Booster: ____/___/____

4. POLIO: Date1: ___/___/___
   Three does; Booster only if needed for travel. Date 2: ____/___/___
   Date 3: ___/___/____

5. VARICELLA VACCINE (Chicken Pox):
   Two properly spaced doses of varicella vaccine or laboratory evidence of Immunity. History of Varicella disease (Chickenpox) alone is not acceptable. Date 1: ___/___/___
   Date 2: ___/___/___

6. HEPATITIS B: Series of 3 doses; 0, 1- 2, 6-12 months Date 1: ___/___/___ Date 2: ___/___/___ Date 3: ___/___/___
   Surface Antibody Titer (IGg) is required once the series is completed to prove immunity for Clinical Professional Programs.
   Attach lab results.

7. TUBERCULOSIS TESTING (within the past year) - Recommended for all students; only REQUIRED for:
   - Education Majors and Clinical Professional Program
   - Anyone who has lived in or visited South America, Central America, Easter Europe, Asia or Africa in the last 5 years
   - Students in contact with a known case

TUBERCULOSIS TESTING (PPD)	If required: chest x-ray results:
Date: _____ Result: ___ Neg ___ Pos Induration _____mm	___Normal ___Abnormal (M/D/Y/) _____

A QuantiFERON-TB Gold (QTF) or T-Spot test is the recommended method for TB infection screening. PPD's will only be accepted for low risk students in the education program.

A chest x-ray is required if the student has a positive PPD or QuantiFERON Gold. If the student has had a positive tuberculin test, did he/she receive prophylactic medication? Yes ____ No ____

8. MENINGOCOCCAL QUADRIVALENT VACCINE (A, C, Y, W-135): _____Menomune _____Menactra _____Menveo
   PA State Law requires students living in campus housing to have documentation of a dose of conjugated vaccine. Vaccination is recommended at 11-12 years of age with a booster at/after age 16. Date 1: ___/___/___ Date 2: ___/___/___

□**DECLINE:** I have read the enclosed information about Meningococcal Meningitis vaccine; however, I decline the vaccine at this time. I understand that in declining this vaccine, I continue to be at risk for this serious disease. I further understand that if I change my mind In the future and want the vaccine, I can receive it at the Student Health Center. **If student under the age of 18, parental consent is necessary.**

_____ _____ _____ _____

Student Signature Date Parent Signature (if under 18) Date

RECOMMENDED IMMUNIZATIONS:

HEPATITIS A: Series of 2 doses; 0, 6 months Date 1: ___/___/___ Date 2: ___/___/___

MENINGOCOCCAL B VACCINE: Bexsero Date 1: ___/___/___ Trumenba Date 1: ___/___/___
Date 2: ___/___/___ Date 2: ___/___/___
Date 3: ___/___/___