California University of Pennsylvania
Building Character. Building Careers.
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A proud member of the Pennsylvania State System of Higher Education.

**University Wellness Center**
**Carter Hall**
**250 University Avenue**
**California, Pennsylvania 15419-1394**
**Phone: (724) 938-4232 FAX:(724) 938-4509**

**ATHLETES**

**It is your responsibility to make a copy of this form and send it to the Athletic Department**

**and send the original to the Health Center.**

# MEDICAL INFORMATION FORM

***Please make a copy of all forms for your personal records.***

**Date of Admission:**

Summer_____Spring_____Fall_____ 20_____

___ Check here if you are an International student

## Student Information:

____Male _____Female

Name:_____
Last

_____
First Middle Name

Home Address:_____
Street

_____
City State Zip Code

Phone: (Area Code)_____ Cell:_____ _____

Date of Birth:_____

CWID: _____

Citizen of:___USA ___Other _____
Name of Country

## Emergency Notification:

Name:_____

Relationship:_____

Address:_____
Street

_____
City State Zip Code

Home Phone: (Area Code)_____

Cell Phone: (Area Code): _____

Work Phone: (Area Code)_____

***It is MANDATORY that ALL F-1VISA International Students and ALL NCAA Athletes must show proof of Health Insurance.***
**For any student who wants to purchase coverage, information can be found at www.calu.edu/Student Health Insurance or at www.chpstudent.com.**

PLEASE PROVIDE YOUR CURRENT HEALTH INSURANCE INFORMATION:

Insurance Company Name:_____

Insurance Company Address:_____

Policy Holder's Name: _____

Policy Holder's Home Address:_____

Policy Number:_____(ID Number) Group Number:_____

I hereby give permission to the University Wellness Center Nurse/Nurse Practitioner or MD Physician of his/her choice, to prescribe necessary medication and/or perform treatments necessary in the best interest of my health needs. I understand that my parents or guardians will be notified of any serious illness or hospitalization (Only incoming students under 18 years of age must have medical information form notarized).

_____ _____

(Signature of Student) (Date) (Signature of Parent or Guardian of Minor)

**California University of Pennsylvania Student Health Center Office Use Only**

Insurance Information Complete? ___Yes ___No CWID#_____

Medical Information Form and Physical Exam Complete? ___Yes ___No

Record is incomplete or requires follow-up for:

PPD:_____Hx:_____Physical:_____ Form Reviewed By_____

## Personal Health History

_____ CWID # _____

(Last Name) (First Name) (Middle Name)

| **Do you or have you ever had?** | Yes | No |
|---|---|---|
| Rheumatic/Scarlet Fever | | |
| Measles (Rubeola)) | | |
| German Measles (Rubella) | | |
| Mumps | | |
| Chicken Pox | | |
| Tuberculosis | | |
| Diabetes | | |
| Heart Disorders | | |
| High or Low Blood Pressure | | |
| Kidney Disorders | | |
| Tumor/Cancer | | |
| Hepatitis (Specify Type) | | |
| Epilepsy/Seizure Disorder | | |
| Mononucleosis | | |
| Stomach/Intestinal diseases | | |
| (specify) | | |
| HIV/AIDS | | |
| Eye disorders/disease | | |
| Recurrent Sinusitis | | |
| Recurrent ear infections | | |
| Seasonal allergies | | |
| Asthma | | |
| Allergy injections | | |
| Thyroid Conditions | | |
| Sickle Cell Anemia | | |
| Other | | |

| **Have you been treated or hospitalized for:** | Yes | No |
|---|---|---|
| Anxiety | | |
| Depression | | |
| Hyperactivity/ADD | | |
| Bipolar illness | | |
| Eating disorders | | |
| (Specify) | | |
| | | |
| Head injury | | |
| Other | | |
| | | |
| **Surgical Procedures:** | | |
| Appendectomy | | |
| Tonsillectomy | | |
| Other: | | |
| Bone/joint surgery/disease | | |
| (Specify) | | |
| Allergies to Medicines: | | |
| (Specify) | | |
| | | |
| | | |
| Allergies to Food & Additives: | | |
| (Specify) | | |

## FAMILY HISTORY

Have any of your relatives had any of the following conditions?

| | Yes | No | Relationship | | Yes | No | Relationship |
|---|---|---|---|---|---|---|---|
| Tuberculosis | | | | Cancer (Specify) | | | |
| Diabetes | | | | Asthma | | | |
| Kidney Disease | | | | Epilepsy | | | |
| Heart Disease | | | | Alcohol/Drug Abuse | | | |

Remarks and Additional Information: _____

# Immunization Record

| | |
|---|---|
| | CWID# |
| (Last Name) (First Name) (Middle Name) | |

**IMMUNIZATION REQUIREMENTS**

Due to the regular incidence of dangerous communicable diseases on college campuses, the American College Health Association has asked that all colleges and universities institute an immunization policy which would require proof of sufficient immunity prior to class registration. In keeping with this, the California University Student Health Center has developed immunization requirements which must be met prior to class registration.

Measles (Rubeola) Immunization must be performed with "live" measles vaccine on or after the first birthday. If born in or after 1957, documentation of a second dose of vaccine is required. Administration of a second MMR II is recommended by the CDC. A history of the disease is not adequate proof of immunity. Mumps Immunization must be performed after the first birthday.

Primary and secondary schools in all states now require current immunizations. You may contact your high school for a copy of your immunization record. We thank you for your cooperation.

***Waiver of these immunization requirements occurs only in case of medical contradiction, documented by your physician or religious objection, documented by your religious leader.**

**PLEASE COMPLETE**

Tuberculin Skin Test
PPD by Mantoux Method
Date of test: _____
***Mandatory (within the past 12 months)***

**Mandatory Signature**

Date of reading:_____

Negative… _____mm
Positive… _____mm
Treatment:_____

**Mandatory Signature**

**or**

Chest X-ray Date:
Negative… _____
Positive… _____
Treatment:_____

**Mandatory Signature**

| **Immunization Record** Please List All Dates | **Date of Last Immunization** |
|---|---|
| DPT - | |
| Polio - | |
| MMR I - | |
| MMR II - | |
| Measles(Rubeola) - | |
| Mumps - | |
| Rubella (German Measles) - | |
| Varicella (Chickenpox) - | |
| Tetanus - Td (within the last 10 years) | |
| Hepatitis B (RECOMMENDED) - List Dates | |
| Dose 1:____ Dose 2:____ Dose 3:____ | |
| Meningitis Vaccine - | |
| HPV Vaccine (Gardasil) Dose 1:_____Dose 2:_____Dose3:_____ | |
| **** Athletes:*** Sickle Cell Testing - Positive _____ Negative _____ | **Testing Date** |

****Pennsylvania State Law requires ALL students residing in residence halls provide proof of meningitis vaccine or sign a waiver.***

****Effective August 1, 2012 Sickle Cell testing is mandated for all athletes. Athletes will need to take a test, provide proof that they have already taken a test, or sign a waiver to opt out.***

## THIS SECTION IS FOR YOUR PHYSICIAN TO COMPLETE

Physical Examination

_____ CWID#_____

(Last Name) (First Name) (Middle Name)

____Male ____Female

BP:_____/_____ Ht:_____ Wt:_____lbs.

Corrected Vision: R20/ L 20/ Uncorrected Vision: R20/ L20/

Assessment of Hearing Acuity: Assessment of Dental Hygiene:

Medications (List Each Dosage) 1:_____Dosage_____
2:_____Dosage_____
3:_____Dosage_____

Drug Allergies:_____Type of Reaction:_____
_____

Is there loss or seriously impaired function of any organ? Yes_____ No_____
General Comments?_____
Recommendations for physical activity (Physical Education, Athletics, etc.) Unlimited:_____Limited:_____
Explain:_____
Is the patient now under treatment for any medical or emotional condition? Yes_____ No_____
If yes, please explain:_____
Do you have any recommendations regarding the care of this student? Yes_____ No_____
If yes, please explain:_____
Are there any abnormalities of the following systems? Describe fully. Use an additional sheet if necessary.

| | Yes | No |
|---|---|---|
| Head, Ears, Nose, Throat<br>Respiratory | | |
| Cardiovascular | | |
| Gastrointestinal | | |
| Hernia | | |
| Eyes | | |

| | Yes | No |
|---|---|---|
| Genitourinary | | |
| Musculoskeletal | | |
| Metabolic/Endocrine | | |
| Neuropsychiatric | | |

Comments:_____

_____ Date:_____
(Physician's Signature)

_____
(Physician's Name - Printed)

Address:_____ Phone#:_____