MERCYHURST UNIVERSITY

Fall 2015

Dear Student/Parent:

These health record forms are required from all incoming students (freshman, transfer students) by **August 1, 2015**. Students who plan to reside in campus housing during summer 2014 must provide these completed forms prior to the summer move-in date. The forms include:

- **Sections I – IV** (pages 2 & 3)should be completed by the student.
- **Sections V- VII** (pages 4 – 9) should each be completed, signed, and dated by the health care provider (physician, physician's assistant, nurse practitioner). These sections include the results of a physical examination conducted within one year of the start date at Mercyhurst, a TB assessment, and immunization record.
- A **meningitis waiver** is available on the Health Center site on the Mercyhurst portal under "forms and documents, and is to be completed ONLY by students who have chosen **not** to receive a meningitis vaccine due to religious, medical, or other reasons. Pennsylvania law requires a meningitis vaccine for students living in campus housing. A student cannot move into housing without evidence of a vaccine, or a signed waiver on file.

Student athletes must submit this health record directly to the Cohen Student Health Center even though the Athletics program may ask for additional health information for its records.

Immunizations are not provided on campus, so please be sure they are up to date prior to coming to Mercyhurst. The Advisory Council on Immunization Practices (ACIP) recommends Gardasil to prevent genital lesions and cervical cancer. Please talk with your health care provider about this three-inoculation series available for men and women.

Allergy shots can, in most case, be provided on campus. For information, go to the Cohen Student Health Center site on the Mercyhurst internet portal. Click on "Forms and documents" for allergy shot information and forms.

Meningitis. Pennsylvania law requires that all students who will be living in campus housing and who are age 25 or younger must submit proof of one dose of meningococcal conjugate vaccine that covers serogroups A, C, Y and W-135. ACIP recommends that aadolescents who receive their first dose at age 13 through 15 years should receive a booster dose at age 16 through18 years.

International Students. The meningitis vaccine received in the home country sometimes does not include A, C, Y and W-135 which are the most common strains in the United States. Students should speak with their physician to assure that the correct strains are covered in order to avoid having to obtain additional immunization upon arrival to the U.S.

Please fax these completed forms (FAX: 814-824-2242) or mail them to: Mercyhurst University/ Cohen Student Health Center/ 501 E. 38th Street/ Erie, PA 16546. Our staff can be reached at 814-824-2431, Monday-Friday, 8:30 a.m. to 4:00 p.m. or at health@mercyhurst.edu. Calls/emails are still returned within a few days during summer break.

Sincerely,

Judy Smith, Ph.D.

Judy Smith, Ph.D.
Executive Director of Wellness
Cohen Student Health Center

MERCYHURST UNIVERSITY

PRE-ADMISSION HEALTH RECORD

***PLEASE PRINT CLEARLY* – Sections I through IV are completed by the student/parent.**

I.

1. Name in Full: _____ Sex: M____ F____
   Last First Middle

2. Home Address: _____
   Street City State Zip

   Home Phone: (_____)_____ Student Cell Phone: (_____)_____

3. Age: ____ Date of Birth:_____ Marital Status _____

4. Name of Parents/Spouse: _____

5. Insurance Co: _____ Policy # _____

6. Is referral from Primary Care physician needed? Y / N

7. Student's email address: _____

II.

1. In Case of Illness/Emergency Notify:_____

2. Relationship to Student: _____ Phone # (_____)_____

   Address: _____
   Street City State Zip

I authorize the medical service of Mercyhurst University to provide appropriate treatment for any illness or injury.

_____
Student's Signature Parent/Guardian Signature *(if student is under 18 years of age)* Date

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III.

1. List ***all known*** allergies to medications, foods and/or environmental allergens: _____
   _____

2. List any illness, injury, or surgery you **have had:** _____
   _____

3. List **any** health problems or chronic illnesses you ***presently*** have:
   _____

   _____

4. Are you presently under a physician's care? **Y / N** If so, list any **medications y**ou are currently taking:_____
   _____

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

Student Name: _____ **D.O.B.:** _____

III. (continued)

5. Do you take allergy shots? **Y/N.** If yes, and you would like to receive your shot on campus, please call our office at 814- 824-2431.

FAMILY HEALTH RECORD

	HISTORY	IMMEDIATE FAMILY MEMBER	IF DECEASED	CAUSE
IV.	Alcoholism			
	Cancer			
	Diabetes			
	Heart Disease			
	Hypertension			
	Mental Illness			
	Thyroid Disease			

Please add any information below that you feel we should know regarding your health or health concerns:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MERCYHURST UNIVERSITY

MERCYHURST UNIVERSITY PRE-ADMISSION HEALTH RECORD

SECTIONS V (Physical Examination), VI (TB Assessment), and VII (Immunization History) are to be completed by the physician (or NP/PA). Each section requires a signature and date.

Please return this completed packet to the student/family. If you are asked to return this directly to Mercyhurst, send it to:

Mercyhurst University
Cohen Student Health Center
501 East 38th Street
Erie, PA 16546
814-824-2037 or 814-824-2431
FAX: 814-824-2242

V. PHYSICAL EXAMINATION -*THIS SECTION TO BE COMPLETED BY PHYSICIAN (or NP/PA)*

Name of Applicant: _____Ht _____ Wt _____ BP_____

Systems Assessment:

1. Eyes: R 20/ L 20/ Normal _____ Abnormal _____
2. Ears: Canal: Normal _____ Abnormal _____ T.M.: Normal: _____ Abnormal: _____
3. Throat: Tonsils: Present _____ Absent _____

   Have you ever had "Strep Throat"? Y / N If yes, Date: _____ Rx _____
4. Mouth: Tongue: Normal _____ Abnormal _____ Teeth: Normal _____ Abnormal _____
5. Posture: Spine: Normal _____ Kyphosis _____ Lordosis _____ Scoliosis _____
6. Skin: Normal _____ Abnormal _____ Piercing sites_____ Tattoos_____
7. Lungs: Clear to percussion and auscultation _____
8. Lymphatics: Thyroid: Normal ____ Abnormal ____ Lymph Nodes: Normal ____ Abnormal ____
9. Heart: Rate: _____ Rhythm: _____ PMI: _____ S1 & S2: _____

   Extra Sounds: _____ Murmurs: _____
10. Abdomen: Normal: _____ Abnormal: _____
11. Inguinal Area: Normal: _____ Abnormal: _____ Hernia: _____
12. C.N.S.: Normal: _____ Abnormal: _____
13. Does this student have ***any condition*** which would interfere with activities? Y / N
    If yes, specify: _____

    Recommendation: _____

Date of Examination: _____ (Must be completed within 12 months of the start of upcoming college year)

MD, DO, NP or PA Signature: _____ Printed Name: _____

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

VI. TUBERCULOSIS (TB) SCREENING/TESTING[1]

HEALTHCARE PROVIDER: PLEASE ASK THE STUDENT THE SIX QUESTIONS BELOW TO DETERMINE IF TB TESTING IS INDICATED:

1. **Have you ever had close contact with persons known or suspected to have active TB disease?** ❑ Yes ❑ No
2. **Were you born in one of the countries listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)** ❑ Yes ❑ No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
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
Gabon
Gambia
Georgia
Ghana
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Iran
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
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nauru
Nicaragua
Niger
Nigeria
Niue
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
Sri Lanka
South Sudan
Sudan
Suriname
Swaziland
Tajikistan
Thailand
Timor-Leste
Togo
Trinidad & Tobago
Tunisia
Turkey
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 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

3. **Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)** ❑ Yes ❑ No
4. **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
5. **Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?** ❑ Yes ❑ No
6. **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, Mercyhurst University requires TB testing prior to starting at the University (*turn to next page*).
If the answer to all of the above questions is NO, no testing or further action is required (*sign TB form on page 7, and then proceed to Immunization History form on page 8).*

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

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

VII. TUBERCULOSIS (TB) RISK ASSESSMENT (*to be completed by health care provider*)

Is there a history of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes _____ No _____**

Is there a history of BCG vaccination? (If yes, consider IGRA if possible.) **Yes _____ No _____**

If the student answered YES to any of the questions on the prior page, the student should receive either the Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) at this time (provided that you did not answer " yes" to any of the questions above regarding a previous positive TB test).

Please be certain to also consider whether there are any current active signs of TB that might require additional evaluation (#1 below)

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____ No _____

If No, proceed to either the TST (#2) or IGRA (#3)

If Yes, check below and proceed with additional evaluation as indicated including tuberculin skin testing, chest x-ray, and sputum evaluation.

- ❑ Cough (especially if lasting for 3 weeks or longer) with or without sputum production
- ❑ Coughing up blood (hemoptysis)
- ❑ Chest pain
- ❑ Loss of appetite
- ❑ Unexplained weight loss
- ❑ Night sweats
- ❑ Fever.

2. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ____/____/____ (M D Y) Date Read: ____/____/____ (M D Y)

Result: _____ mm of induration **Interpretation: 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

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

Student Name: _____ D.O.B.: _____

- 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.

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

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: ____/____/____ (specify method) QFT-GIT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

4. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ____/____/____ Result: normal____ abnormal_____
M D Y

Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

- ❑ Infected with HIV
- ❑ Recently infected with *M. tuberculosis* (within the past 2 years)
- ❑ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ❑ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ❑ Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
- ❑ Have had a gastrectomy or jejunoileal bypass
- ❑ Weigh less than 90% of their ideal body weight
- ❑ Cigarette smokers and persons who abuse drugs and/or alcohol

••Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations

_____Student agrees to receive treatment

_____Student declines treatment at this time

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

Immunization and TB Screening Prepared by ACHA's Vaccine-Preventable Diseases Advisory Committee

American College Health Association

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

VII. IMMUNIZATION RECORD

This section is to be completed and signed by your Health Care Provider. All information must be in English.

Name _____ _____
First Name Middle Name

_____ _____
Last Name Date of Birth

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

1. Dose 1 given at age 12 months or later ..... #1 ____/____/_____ (M D Y)
2. Dose 2 given at least 28 days after first dose ..... #2 ____/____/_____ (M D Y)

B. POLIO

(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y)
2. IPV/OPV sequential: IPV #1 ____/____/_____ (M D Y) IPV #2 ____/____/_____ (M D Y) OPV #3 ____/____/_____ (M D Y) OPV #4 ____/____/_____ (M D Y)
3. IPV alone (injected Salk four doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y) #4 ____/____/_____ (M D Y)

C. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___
2. Varicella antibody ____/____/_____ (M D Y) Result: Reactive _____ Non-reactive _____
3. Immunization
   a. Dose #1 ..... #1 ____/____/_____ (M D Y)
   b. Dose #2 given at least 12 weeks after first dose ages 1-12 years..... #2 ____/____/_____ (M D Y)
   and at least 4 weeks after first dose if age 13 years or older.

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___

   Date of <u>last</u> dose in series: ____/____/_____ (M D Y)

2. Date of most recent booster dose: ____/____/_____ (M D Y)

   Type of booster: Td _____ Tdap _____ ***Tdap booster recommended for ages 11-64 unless contraindicated.**

E. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4) (females and males, ages 9-26, three doses at 0, 1-2, and 6 month intervals.)

Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____

a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

PRE-ADMISSION HEALTH RECORD

Continued from previous page…

Student Name: _____ D.O.B.: _____

F. INFLUENZA

Date of last dose: ____/____/_____
M D Y

Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

G. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

H. HEPATITIS B

(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

   Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

   M D Y M D Y M D Y

3. Hepatitis B surface antibody Date ____/____/_____ (M D Y) Result: Reactive _____ Non-reactive _____

I. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

(One dose for members of high-risk groups.)

Date ____/____/_____
M D Y

J. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) ***ACIP recommends that adolescents who receive their first dose at age 13 through 15 years should receive a booster dose at age 16 through18 years.*

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

   Date ____/____/_____
   M D Y

MD, DO, NP or PA Signature: _____ Phone #: _____

PRINTED NAME: _____