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 adolescents who receive their first dose at age 13 through 15 years should receive a booster dose at age 16 through 18 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
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.

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 you are currently
taking:__________________________________________________________________________________
   ______________________________________________________________________________________
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

<table>
<thead>
<tr>
<th>HISTORY</th>
<th>IMMEDIATE FAMILY MEMBER</th>
<th>IF DECEASED</th>
<th>CAUSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV. Alcoholism</td>
<td>___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td>___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>___________________________</td>
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<tr>
<td>Heart Disease</td>
<td>___________________________</td>
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<td>Hypertension</td>
<td>___________________________</td>
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<tr>
<td>Mental Illness</td>
<td>___________________________</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Disease</td>
<td>___________________________</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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 _______
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: ___________________
VI. TUBERCULOSIS (TB) SCREENING/TESTING

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

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.
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: ___/___/____  Date Read: ___/___/____

M     D       Y        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
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 jejunileal 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 jejunileal 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
### VII. IMMUNIZATION RECORD

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

<table>
<thead>
<tr>
<th>Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

#### 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 __/__/____     #2 __/__/____     #3 __/__/____
   M  D  Y         M  D  Y                  M  D  Y
2. IPV/OPV sequential:     IPV #1 __/__/____     IPV #2 __/__/____     OPV #3 __/__/____     OPV #4 __/__/____
   M  D  Y                 M  D  Y                M  D  Y               M  D  Y
3. IPV alone (injected Salk four doses):     #1 __/__/____     #2 __/__/____     #3 __/__/____     #4 __/__/____
   M  D  Y         M  D  Y                  M  D  Y         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 __/__/____ Result:     Reactive ________     Non-reactive ________
   M  D  Y
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 __/__/____
      and at least 4 weeks after first dose if age 13 years or older.                     M  D  Y

#### D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed?     Yes ___     No ___
   Date of last 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.)

<table>
<thead>
<tr>
<th>Immunization (indicate which preparation)</th>
<th>Quadrivalent (HPV4)</th>
<th>Bivalent (HPV2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Dose #1 <strong>/</strong>/____</td>
<td>b. Dose #2 <strong>/</strong>/____</td>
<td>c. Dose #3 <strong>/</strong>/____</td>
</tr>
<tr>
<td>M  D  Y</td>
<td>M  D  Y</td>
<td>M  D  Y</td>
</tr>
</tbody>
</table>
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 ____/____/________  b. Dose #2 ____/____/________
      M       D           Y                        M       D           Y

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ____/____/________  b. Dose #2 ____/____/________  c. Dose #3 ____/____/________
      M       D           Y                    M       D           Y             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 ____/____/________  b. Dose #2 ____/____/________  c. Dose #3 ____/____/________
      M       D           Y                        M       D           Y             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

3. Hepatitis B surface antibody  Date ____/____/________  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 through 18 years.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/________  b. Dose #2 ____/____/________
      M       D           Y                        M       D           Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).
   Date ____/____/________

MD, DO, NP or PA Signature: ________________________________  Phone #: __________________

PRINTED NAME: ____________________________________________