DEPARTMENT OF PHYSICIAN ASSISTANT STUDIES
STUDENT HEALTH RECORD

Dear Student,

Welcome to the Mercyhurst University Department of Physician Assistant Studies. We look forward to you joining us in May.

The enclosed Mercyhurst Student Health Record is required for all graduate students entering the PA Program. A completed Student Health Record, which includes the Pre-Admission Immunization Record and the Cohen Health Center Student Health Record, is required for matriculation into the Program. This health record is necessary for your access to services at the Cohen Health Center and for use in providing clinical affiliate sites proof of immunizations, titers and wellness.

***All forms must be completed and on file in the Cohen Student Health Center by April 15, 2020.**

It is the student's responsibility to either mail, email or fax the completed forms along with all supporting documents to the Cohen Student Health Center via Fax #814-824-2242 or email: health@mercyhurst.edu

*** The physical examination and TB screening for the Cohen Health Center Student Health Record must be completed after March 1, 2020 and no later than April 15, 2020.**

*** <u>Upon acceptance</u>, the Pre-Admission Immunization Record, including the documentation of immunization and quantitative titers should be verified and submitted to Cohen Health Center.** Students are required to provide current immunization and serologic immunity verification throughout enrollment in the program in accordance with CDC guidelines. Immunizations, with the exception of the flu vaccine, are not provided on campus at the Cohen Student Health Center and must be completed **prior to matriculation**. Immunization and quantitative titers **including a copy of the laboratory report** showing the level of immunity are required for documentation.
**** Please note important instructions regarding equivocal or negative immunization titers within this packet. Do not wait to begin this process as re-immunization and titers may be required.**

Please be aware that Pennsylvania requires any college student, age 25 or less, residing in campus-owned housing, to have received a meningitis vaccine, or to sign a waiver if the vaccine is being refused for medical or religious reasons. Additional information including a waiver form, if needed, is enclosed.

If you have any questions in completing the health record, please contact the Cohen Student Health Center staff at **814-824-2431** (M-F, 8:30am-4:00pm). During summer break, leave a message and your call will be returned within a few days.

All completed health record forms are due by April 15, 2020 and should be sent to the:

Cohen Student Health Center
Mercyhurst University
501 East 38th Street
Erie, PA 16546

Records may be faxed to (814) 824-2242 or emailed to health@mercyhurst.edu

For Student of the
Department of Physician Assistant Studies

COHEN HEALTH CENTER STUDENT HEALTH RECORD

All questions contained in this questionnaire are strictly confidential and will become part of your student medical record.

Name *(Last, First, M.I.):*	☐ M ☐ F	**DOB:**
Current Address *(Street, City, State, Zip):*		
Mobile Phone:	**Home Phone:**	
Primary Care Physician's Name:	**Primary Care Physician's Phone Number:**	
Health Insurance Provider:	**Health Insurance Policy Number:**	
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

In Case of Illness/Emergency Please Notify:	**Mobile Phone:** (enter below)	**Home Phone:** (enter below)	**Work Phone:** (enter below)
Relationship to Student: ☐ Parent ☐ Spouse ☐ Partner ☐ Friend			

Cohen Student Health Center of Mercyhurst University provides outpatient medical service to Erie campus students. My signature below authorizes the Center to provide appropriate treatment to me for any illness or injury. My signature also authorizes the release of this Record and the Pre-Admission Immunization Record or portions thereof as required to any clinical sites that I am pursuing as a student. This authorization remains in effect throughout my tenure as a DPAS/Mercyhurst University student.

Student Signature: ____ Date: _______________________

PERSONAL HEALTH HISTORY

Are you presently under a physician's care? ☐ Yes ☐ No

List any medical problems including health problems, chronic illness, injuries, or mental health concerns

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PHYSICAL EXAMINATION: THIS SECTION MUST BE COMPLETED BY THE STUDENT'S HEALTHCARE PROVIDER

Eyes: R 20/_____ L 20/_____ Normal _____ Abnormal (describe):

Ears: EAC: Normal _____ Abnormal (describe):

TMS: Normal _____ Abnormal (describe):

Throat: Tonsils Present: ☐ Yes ☐ No

Mouth: Tongue: Normal _____ Abnormal (describe):

Teeth: Normal _____ Abnormal (describe):

Heart: Rhythm __________ Rate ___________ Blood Pressure _______ / _______

Lungs: Clear _____ Abnormal (describe):

Abdomen: Normal _____ Abnormal (describe):

Lymphatics: Lymph Nodes: Normal ______ Abnormal (describe):

Thyroid: Normal _____ Abnormal (describe):

Skin: Normal _____ Abnormal (describe):

C.N.S.: Normal _____ Abnormal (describe):

Inguinal area: Normal _____ Abnormal (describe): Hernia?

Does this student have any condition which would interfere with activities? ☐ Yes ☐ No

If Yes, specify: ____

Recommendations: ____

TUBERCULOSIS SCREENING

A 2-step Mantoux/PPD is required.

(A history of BCG vaccination should not preclude testing of a member of a high-risk group)

Step 1: Date Given ____________ Date Read ___________

Result: _________mm Interpretation: ☐ positive ☐ negative

****Second step given 7-21 days after first step is read.**

Step 2: Date Given ____________ Date Read ___________

Result: _________mm Interpretation: ☐ positive ☐ negative

If an individual has had a positive Mantoux/PPD in the past 12 months, a chest x-ray is required within one year and TB symptom 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

Date of chest x-ray: _____________ ☐ normal ☐ abnormal

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 recommended treatment at this time – this will preclude patient contact

HEALTH CARE PROVIDER SIGNATURE REQUIRED

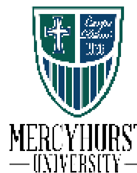
MD/DO/NP/PA Name (Please Print): ____

Practice Name (Please Print): ____

Address: ____

Phone: ______________________________

MD/DO/NP/PA Signature (required): ____



PRE-ADMISSION IMMUNIZATION RECORD

Student Health Record

Cohen Health Center of Mercyhurst University provides outpatient medical service to Erie campus students. My signature below authorizes the Center to release this Record of portions thereof to the Department of Physician Assistant Studies and as required to any clinical sites that I am pursuing as a student. This authorization remains in effect throughout my tenure as a DPAS/Mercyhurst University student.

Student Signature: ____ Date: _______________________

SECTION 1: Titer results including copies of lab documentation.

Positive antibody titers are required for measles, mumps, rubella, varicella and Hepatitis B. You must provide laboratory documentation of positive titers, even if you have previously had vaccinations for MMR, Varicella and Hepatitis B. **If a titer is negative or equivocal, the proper vaccines will be required and a repeat titer will be necessary.**

Varicella (Chicken Pox): Lab documentation is required for a positive **Varicella IgG titer**. If the titer is negative or equivocal, the student will need to proceed with the varicella vaccines (a 2 step vaccine: initial vaccine with a 4 week lapse for the second dose), followed 4-8 weeks later by another Varicella IgG **titer** with lab documentation showing proof of immunity (positive/immune results).

MMR: Lab documentation is required for the **Mumps IgG titer, Rubella IgG titer** and **Rubeola IgG titer**. If any of the titers are native or equivocal, the student will need to proceed with the 2-step MMR vaccine (a 2-step vaccine: initial vaccine and a 4-week wait prior to the second dose), followed 4-8 weeks later by another MMR IgG **titer** with lab documentation showing proof of immunity (positive/immune result).

Hepatitis B: A **Quantitative Hepatitis B Surface Antibody titer** (not qualitative) is required with lab documentation showing proof of immunity (positive/immune result). If the titer is negative or equivocal, despite having had the three-shot series, another three-shot series must be repeated and followed 4-8 weeks later by another titer. Due to the length of time it takes to complete the series, it is vital that you find out your immunity status AS SOON AS POSSIBLE.

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

IMMUNIZATION RECORD

Name in Full (First Middle Last): ____

Age: _________________ Date of Birth: ____

MMR (MEASLES, MUMPS, RUBELLA) – two doses required at least 28 days apart

Immunization AND serologic confirmation of immunity required. **Attach copy of quantitative lab report.**

Immunization date Dose #1 ___/___/___ given at age 12 months or later
Immunization date Dose #2 ___/___/___ given at least 28 days after first dose
Mumps titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal
Rubeola titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal
Rubella titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal

VARICELLA – Dose #2 should be given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after first dose if age 13 years or older.

Immunization AND serologic confirmation of immunity required. **Attach copy of quantitative lab report.**

History of Disease Yes____ No____
Immunization date Dose #1 ___/___/___
Dose #2 ___/___/___
Varicella titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal

PRE-ADMISSION IMMUNIZATION RECORD

Student Health Record

Immunization **AND** serologic confirmation of immunity required. **Attach copy of quantitative lab report.**

HEPATITIS B – All college and health care professional students.
Immunization dates**:** Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
Hepatitis B Surface Antibody: Quantitative titer Date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal

TETANUS, DIPHTHERIA, PERTUSSIS
Primary series completed? Yes ___ No ___ Date of last dose in series: ___/___/___
Date of most recent booster dose: ___/___/___
Type of booster: Td___ Tdap ___ *Tdap booster recommended for ages 11-64 unless contraindicated.

POLIO
Primary series in childhood meets requirements; three primary series schedules are acceptable. Refer to ACIP for details:
1. OPV alone (oral Sabin three doses) Dates: #1 __________ #2______________#3 _____________
2. IPV alone (injected Salk four doses) Dates: #1 __________ #2______________#3 _____________ #4_____________
3. IPV/OPV sequential: Dates: IPV#1 __________ IPV#2____________OPV#3 __________ OPV#4__________

INFLUENZA
Date of last dose: ___/___/___ Trivalent/Quadrivalent ☐ Inactivated influenza vaccine (TIV) ☐ Live attenuated influenza vaccine (LAIV)

MENINGOCOCCAL MENINGITIS
Menomune A/C/Y/W-135 - Quadrivalent polysaccharide vaccine Date: ___/___/___

A Meningitis waiver is attached to this form. A **meningitis waiver** is available on the Cohen 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 the meningitis vaccine due to religious, medical, or other reasons. Pennsylvania law requires a meningitis vaccine for all students under the age of 25 living in campus housing. A student cannot move into housing without evidence of a vaccine or a signed waiver on file.

The Meningococcal Meningitis Vaccine or waiver is required by PA state law for all students under the age of 25 living on campus.
If you are not living in campus-owned housing or are older than 25, it is not required.

MD, DO, NP or PA Signature: ____**Date:** _______________

PRINTED NAME:____**Phone #:** ______________

SECTION 2: Re-Vaccination and repeat titer dates for negative or equivocal titers

** Laboratory copies of positive quantitative titers must be included **

Varicella 1. _____________________________ 2. _____________________________
Varicella titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal

MMR – Two vaccines 28 days apart and repeat titers 4-8 weeks after the second vaccination
Dates of Vaccines: 1. _____________________ 2. _____________________________
Mumps titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal
Rubeola titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal
Rubella titer date ___/___/___ Result ____________ ☐ Immune positive ☐ Negative or Equivocal

Hepatitis B
Dates of Vaccines: 1. _____________________ 2. _____________________________3. _____________________
Hep B Surface Ab: Quantitative titer Date ___/___/___Result ____________ ☐ Immune positive ☐ Negative or Equivocal

Health Care Provider Signature MD/DO/NP/PA/RN ____
Date: __________________________________

PRE-ADMISSION IMMUNIZATION RECORD

Student Health Record

Students requesting <u>exemption</u> from the meningitis vaccine must read, sign and return this form to Cohen Student Health Center

Dear Student,

In order to be in compliance with Pennsylvania state law, Mercyhurst University requires a meningitis vaccine for incoming freshmen and transfer students under the age of 25 years of age who are living on campus or in campus- owned apartments. <u>If you have already received a meningitis vaccine, you can disregard this form.</u> If you have chosen not to receive the vaccine due to medical, religious, or other reason, the law allows you to waive the vaccine after reading this educational information, and signing the attached form.

International students should be certain to obtain a meningitis vaccine that protects them against the most common U.S. strains - types A, C, Y, and W-135. If an international student does not obtain this, the student will need to sign and return this waiver form, or acquire the appropriate form of the vaccine before starting on campus. The U.S. Centers for Disease Control and Prevention (CDC) and the American College Health Association (ACHA) urge that all first-year students living in residence halls or any campus-owned housing be immunized against meningococcal disease. The CDC recommends that adolescents who received a meningitis vaccine (meningococcal vaccine "conjugate") prior to age 16 receive a booster between the ages of 16 to18 to provide the best protection during the ages of highest risk. **70 percent of all cases of meningococcal disease in college students are vaccine preventable.**

Meningococcal disease is a rare, but potentially fatal, bacterial infection commonly referred to as "meningitis." **Meningococcal bacteria can cause severe disease, including meningitis and sepsis, resulting in permanent disabilities and even death.** Adolescents aged 16 through 21 years have the highest rates of meningococcal disease accounting for nearly 30 percent of all cases in the United States. Approximately 100 to 125 cases of meningococcal disease occur on college campuses each year, and 5 to 15 students will die as a result. Meningitis is a contagious disease that is transmitted by droplets of respiratory secretions in the air from direct contact with an infected person/carrier. Due to lifestyle factors, such as crowded living situations, bar patronage, active or passive smoking, irregular sleep patterns, and sharing of personal items, college students living on campus are more likely to acquire meningococcal disease than the general population. Meningococcal infection progresses very rapidly and is often difficult to diagnose, because early symptoms of the disease such as high fever, severe headache, stiff neck, rash, nausea, vomiting lethargy and confusion also mimic those of the flu. The seasonality of the disease also parallels that of the influenza season. Early treatment is critical.

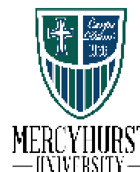
A reformulated meningococcal vaccine ("conjugate") is available that has the potential to provide longer duration of protection against four of the give strains (or types) of bacteria that cause meningococcal disease in the United States – types A, C, Y and W-135. Potential side effects of the vaccine include: possible pain, redness, swelling at the injection site and possibly, fever. As with any vaccine, vaccination against meningitis may not protect 100 percent of the all susceptible individuals. It does not protect against viral meningitis.

Please make sure that you are vaccinated before coming to school and that all immunizations are up to date.

For more information, please contact Cohen Student Health Center **(814-824-2431)** or your family physician.

Sincerely,

Judy Smith, Ph.D.
Executive Director or Wellness



PRE-ADMISSION IMMUNIZATION RECORD

Student Health Record

*****TO BE COMPLETED ONLY IF THE STUDENT DID NOT RECEIVE THE MENINGITIS VACCINE*****

PLEASE PRINT

Student's Name:________________________________ Cell Phone: ________________________________

Date of Birth:________________________________ Home Phone: ________________________________

Address: ____

PLEASE CHECK THIS FORM BELOW IF YOU ARE REQUESTING A WAIVER FOR ANY REASON AND SIGN BELOW

☐ I have received a copy of and have read the letter regarding information about the Meningitis Vaccination. I believe that I understand the benefits and risks of the vaccine required. However, I am requesting exemption from Pennsylvania Act 2002-83, known as the College and University Student Vaccination Act.

My reason for requesting a waiver is due to:

☐ **MEDICAL EXEMPTION:**

The physical condition of the above named student is such that immunization would endanger life or health.

Physician Signature:________________________________Date:______________

☐ **RELIGIOUS EXEMPTION:**

I, ______________________________, adhere to a religious belief whose teachings are opposed to such immunizations.

☐ **OTHER:**

____

Student Signature:________________________________ Date:______________

Parent/Guardian signature if under 18 years old ________________________________Date:______________

Parent/Guardian name PRINTED if under 18 years old ________________________________