



MERCYHURST UNIVERSITY

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 14, 2024. 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, 2024 and no later than April 14, 2024.**

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 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 14, 2024 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

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 <i>(Last, First, M.I.):</i>		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:		
Current Address <i>(Street, City, State, Zip):</i>					
Mobile Phone:		Home Phone:			
Primary Care Physician's Name:		Primary Care Physician's Phone Number:			
Health Insurance Provider:		Health Insurance Policy Number:			
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
In Case of Illness/Emergency Please Notify:	Mobile Phone: <small>(enter below)</small>		Home Phone: <small>(enter below)</small>		Work Phone: <small>(enter below)</small>
Relationship to Student: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Friend					
<p>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.</p>					
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	<input type="checkbox"/> M <input type="checkbox"/> F	
Mother				<input type="checkbox"/> M <input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Maternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandmother <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F		Grandfather <i>Paternal</i>		
	<input type="checkbox"/> M <input type="checkbox"/> F				

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, per CDC guidelines.

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 jejunioileal 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 two or three- shot series, another two or 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 **Please attach copy of immunizations and lab report of all titers.

Name in Full (First Middle Last): _____

Age: _____ Date of Birth: _____

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

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

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

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.

History of Disease Yes ___ No ___

Immunization date Dose #1 ___/___/___

Dose #2 ___/___/___

Varicella titer date ___/___/___ Result _____ Immune positive Negative or Equivocal

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

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:

- OPV alone (oral Sabin three doses) Dates: #1 _____ #2 _____ #3 _____
- IPV alone (injected Salk four doses) Dates: #1 _____ #2 _____ #3 _____ #4 _____
- 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 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: _____

MENINGITIS ON CAMPUS – KNOW YOUR RISK

If you are planning to request a waiver from the meningitis vaccine, you are required to read this information first: Certain college students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. In fact, young adults living in campus housing are found to have up to six-fold increased risk for the disease, given the communal living environment. Pennsylvania law requires that all college students planning to live in campus-owned housing receive a vaccination against meningococcal disease unless the student reviews information about the risks of the disease and the availability of the vaccine, and chooses not to receive the vaccine for religious or other reasons. Please read the following, before signing the waiver on the opposite side of this page.

WHAT IS MENINGOCOCCAL MENINGITIS?

Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column, as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

HOW IS IT SPREAD?

Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

WHAT ARE THE SYMPTOMS?

Symptoms of meningococcal meningitis often are similar to those of the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.

WHO IS AT RISK?

College students, particularly those residing in residence halls or similar large group settings, have been found to have an increased risk for meningococcal meningitis. Other undergraduates can also consider vaccination to reduce their risk for the disease.

CAN MENINGITIS BE PREVENTED?

Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals. At least 70% of all cases of meningococcal disease in college students are vaccine preventable (types A, C, Y, and W135), and the recent approval of an additional meningitis vaccine for type B further increases the efficacy.

FOR MORE INFORMATION: To learn more about meningitis and the vaccine, call the Mercyhurst University Cohen Student Health Center at 814-824-2431, or email the center at health@mercyhurst.edu. You may also visit the websites of the Centers for Disease Control and Prevention (CDC), www.cdc.gov/ncidod/dbmd/diseaseinfo, and the American College Health Association, www.acha.org.

*****COMPLETE ONLY IF REQUESTING EXEMPTION FROM MENINGITIS VACCINE*****

I understand that under Pennsylvania law students enrolled in a Pennsylvania institution of higher education and who reside in on-campus student housing are required to be vaccinated against meningococcal disease, or may seek exemption from this law. I have read the meningitis information available on the previous page where the risks of not obtaining the vaccine are detailed. In addition, I acknowledge the detrimental health effects of the disease. I have also read about and understand the availability and effectiveness of the vaccine.

I do not wish the vaccine, and I voluntarily agree to release, discharge, indemnify and hold harmless Mercyhurst University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the law. I am also aware that in the event of an outbreak of vaccine-preventable diseases, the university will consider and may require temporary exclusion of non-immunized students from school in order to reduce the spread of the disease. Financial refunds or additional time to make up any missed coursework are not guaranteed in the event of mandatory absence under this policy. My grounds for requesting this waiver from Pennsylvania law are:

_____ Medical (in addition to submitting this signed waiver, please include a signed statement from your physician verifying the medical reason the vaccine should not be provided).

_____ Religious (I, _____, adhere to a religious belief whose teachings are opposed to such immunizations.)

_____ Other (please be aware that students requesting a vaccine waiver in this category will be expected to complete a health education session in the upcoming semester designed by the Health Center)

To be filled out by student. If the student is under age 18, a parent/guardian must sign this waiver.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student Signature _____ Date _____

Printed Name of Student _____ Date of Birth _____

Signature of Parent/Guardian (for student under 18) _____ Date _____

Printed Name of Parent/Guardian _____

PLEASE RETURN THIS TO THE COHEN STUDENT HEALTH CENTER. You may fax it (814-347-8275); scan and email it to health@mercyhurst.edu; or mail it to: Cohen Student Health Center, Mercyhurst University • 501 East 38th Street • Erie, PA 16546. If you have any questions, contact the Health Center at 814-824-2431.