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 10, 2026. 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, 2026 and no later than April 10, 2026.**

***The Pre-Admission Immunization Record, including the documentation of immunizations and Quantitative titers should be verified and submitted to Cohen Health Center along with the completed health record.** 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 instruction regarding equivocal or negative titers within this packet. Do not wait to begin this process as re-immunization and titers may be required.**

If you have any questions in completing the health record, please contact the Cohen Student Health Center staff at 814-824-2431 (M-F, 8:30 am-4:00 pm). 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 10, 2026 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

Student Name: _____

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 be come 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 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

Student Name: _____

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				☐ M ☐ F	
Mother				☐ M ☐ F	
	☐ M ☐ F		**Children**	☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
Sibling	☐ 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: R20/_____ L20/_____ 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: _____

Student Name: _____

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

**IMPORTANT: Per CDC guidelines, the second step test should not be placed for at least 7 days (and up to 21 days) AFTER the 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): _____

Student Name: _____

PRE-ADMISSION IMMUNIZATION RECORD

Student Health Record

Cohen Health Center of Mercyhurst University provides outpatient medical service to 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 showing 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 negative 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 Mumps, Rubella or Rubeola 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.

Student Name: _____

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

IMMUNIZATION RECORD **Please attach a copy of immunizations and lab reports of all titers.

Name in Full (First Middle Last):_____

Age:_____ Date of Birth:_____

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

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	____/____/____	Results_____ ☐Immune positive	☐Negative or Equivocal
Rubeola titer date	____/____/____	Results_____ ☐Immune positive	☐Negative or Equivocal
Rubella titer date	____/____/____	Results_____ ☐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.

History of Disease Yes____ No____

Immunization date Dose #1 ____/____/____

Dose #2 ____/____/____

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

Varicella titer date ____/____/____ Result_____ ☐Immune positive ☐Negative or Equivocal

(continued next page)

Student Name: _____

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

COVID-19
Immunization dates: ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____ ____/____/____

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 ____/____/____
3. IPV/OPV sequential: Dates: IPV #1 ____/____/____ IPV #2 ____/____/____ IPV #3 ____/____/____ IPV #4 ____/____/____

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

MENINGOCOCCAL (MENINGITIS)
Meningococcal A/C/Y/W-135 – Quadrivalent polysaccharide vaccine date: ____/____/____

MD, DO, NP or PA Signature: _____Date: _____

Printed Name: _____Phone #: _____

<u>SECTION 2: Re-Vaccination and repeat titer dates for negative or equivocal titers</u>
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 ____/____/____ Results _____ ☐Immune positive ☐Negative or Equivocal
Rubeola titer date ____/____/____Results _____ ☐Immune positive ☐Negative or Equivocal
Rubella titer date ____/____/____ Results _____ ☐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: _____