Dear Student,

These health record forms are required for all graduate students entering the Department of Physician Assistant Studies. **Forms must be completed and on file in the Cohen Student Health Center by June 1st.** This form is necessary for health center access as a patient if an emergency arises and for use in providing clinical affiliates proof of immunizations and wellness. **The physical examination, completed immunization record and titers must be completed no sooner than March 2016 and no later than June 1, 2016.** It is the student’s responsibility to either mail or fax the completed form along with all supporting documents to the Cohen Student Health Center.

Immunizations noted in the health record are not provided on campus in the Cohen Student Health Center and must be completed prior to matriculation. Immunizations and titers along with a copy of the laboratory results report showing the level of immunity are required for documentation.

If you have any questions in completing the health record, please contact the Cohen Student Health Center staff Monday-Friday 8:30am-4:00pm. During summer break, please leave a message and your call will be returned within a few days.

**All completed health record forms 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
Dear Student/Parent:

These health record forms are required from all incoming students (freshman, transfer students) by June, 2016. Students who plan to reside in campus housing during summer 2015 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 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. – 4 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
# HEALTH HISTORY QUESTIONNAIRE

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

<table>
<thead>
<tr>
<th>Name (Last, First, M.I.):</th>
<th>□ M  □ F  DOB:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Address</td>
<td>(Street, City, State, Zip):</td>
</tr>
<tr>
<td>Mobile Phone:</td>
<td>Home Phone:</td>
</tr>
<tr>
<td>Mercyhurst Student ID Number:</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician's Name:</td>
<td>Primary Care Physician's Phone Number:</td>
</tr>
<tr>
<td>Health Insurance Provider:</td>
<td>Health Insurance Policy Number:</td>
</tr>
<tr>
<td>Marital status:</td>
<td>□ Single  □ Partnered  □ Married  □ Separated  □ Divorced  □ Widowed</td>
</tr>
<tr>
<td>In Case of Illness/Emergency Please Notify:</td>
<td>Mobile Phone: (enter below)  Home Phone: (enter below)  Work Phone: (enter below)</td>
</tr>
<tr>
<td>Relationship to Student:</td>
<td>□ Parent  □ Spouse  □ Partner  □ Friend</td>
</tr>
</tbody>
</table>

I authorize the medical service of Mercyhurst University to provide appropriate treatment for any illness or injury. I also authorize release of this information to clinical affiliates of Mercyhurst University as required for clinical experiences.

Student Signature: ___________________________  Date: ________________

## PERSONAL HEALTH HISTORY

<table>
<thead>
<tr>
<th>Are you presently under a physician's care?</th>
<th>□ Yes  □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>List any medical problems including health problems, chronic illness, injuries, or mental health concerns</td>
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</table>

### Surgeries

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>Hospital</th>
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<tbody>
<tr>
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</table>

### Other hospitalizations

<table>
<thead>
<tr>
<th>Year</th>
<th>Reason</th>
<th>Hospital</th>
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<tbody>
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</tbody>
</table>


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

<table>
<thead>
<tr>
<th>Name the Drug</th>
<th>Strength</th>
<th>Frequency Taken</th>
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<tbody>
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</tbody>
</table>

Allergies to medications

<table>
<thead>
<tr>
<th>Name the Drug</th>
<th>Reaction You Had</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>

FAMILY HEALTH HISTORY

<table>
<thead>
<tr>
<th>AGE</th>
<th>SIGNIFICANT HEALTH PROBLEMS</th>
<th>AGE</th>
<th>SIGNIFICANT HEALTH PROBLEMS</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

Father

Mother

Sibling

□ M
□ F

□ M
□ F

□ M
□ F

□ M
□ F

□ M
□ F

Child

Children

□ M
□ F

□ M
□ F

□ M
□ F

□ M
□ F

Grandmother

Grandfather

Maternal

Paternal
**THIS SECTION MUST BE COMPLETED BY THE STUDENT’S HEALTHCARE PROVIDER**

<table>
<thead>
<tr>
<th>Eyes:</th>
<th>R 20/_____</th>
<th>L 20/_____</th>
<th>Normal _____</th>
<th>Abnormal (describe):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears:</td>
<td>EAC: Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TMS:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
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<tr>
<td>Throat:</td>
<td>Tonsils Present: □ Yes □ No</td>
<td></td>
<td></td>
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<tr>
<td>Mouth:</td>
<td>Tongue: Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart:</td>
<td>Rhythm _______</td>
<td>Rate _______</td>
<td>Blood Pressure _______ / _______</td>
<td></td>
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<tr>
<td>Lungs:</td>
<td>Clear _______</td>
<td>Abnormal (describe):</td>
<td></td>
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<tr>
<td>Abdomen:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphatics:</td>
<td>Lymph Nodes: Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C.N.S.:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inguinal area:</td>
<td>Normal _____</td>
<td>Abnormal (describe):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Does this student have any condition which would interfere with activities?

| □ Yes | □ No |

If Yes, specify: ________________________________

Recommendations: ____________________________________________

| Childhood illnesses: | □ Measles | □ Mumps | □ Rubella | □ Chickenpox | □ Polio |

**Immunizations and dates:**

- □ Polio
  - Primary series in childhood meets requirement; three primary series schedules are acceptable. Refer to ACIP for details:
    1. OPV alone (oral Sabin three doses) #1 _______ #2 _______ #3 _______
    2. IPV along (injected Salk four doses) #1 _______ #2 _______ #3 _______ #4 _______
    3. IPV/OPV sequential: IPV#1 ______ IPV#2 ______ OPV#3 ______ OPV#4 ______

- □ Varicella
  1. History of Disease: □ No □ Yes Date: __________
  2. Immunization Dates: #1 _______ #2 _______
  3. Varicella titer Date: __________ □ Positive □ Negative

  *VARICELLA TITER IS REQUIRED. SEND COPY OF LAB REPORT WITH THIS FORM.*

- □ Hepatitis B
  - Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement
    1. Immunization Dates: #1 _______ #2 _______ #3 _______
    2. Titer Date: __________ □ Positive □ Negative

  *HEPATITIS TITER IS REQUIRED. SEND COPY OF LAB REPORT WITH THIS FORM.*

  Non-reactive serological testing must be managed with a dose of hepatitis B vaccine and followup serological testing in 4-6 weeks. If the results are positive, this indicates a booster response. If the test is negative, the second series must be completed (two more doses, 1 and 6 month schedule).
☐ MMR

Immunization #1 _______ #2 _______

BLOOD TITERS MUST BE DRAWN AS AN ADULT (MUMPS, RUBEOLA, AND RUBELLA)

*Copy of report required*

- Mumps Antibody date: ___________ □ Positive □ Negative
- Rubeola Antibody date: ___________ □ Positive □ Negative
- Rubella Antibody date: ___________ □ Positive □ Negative

If titers do not show immunity, a MMR vaccine must be given and immunity documented.

Date of booster: ______________ Antibody date: ___________ □ Positive □ Negative

☐ Tdap

Tdap was licensed in 2005. It is the first vaccine for adults that protect against all three diseases: Tetanus-Diphtheria-Pertussis.

Date Received: __________

☐ Meningococcal Meningitis

Menomune A/C/Y/W-135 – Quadrivalent polysaccharide vaccine Date: ___________

☐ Meningitis waiver is attached to this form. 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.

☐ Influenza Immunization

Date Received: __________
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

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 treatment at this time

HEALTH CARE PROVIDER SIGNATURE REQUIRED

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

Practice Name (Please Print): __________________________________________________________________________________________

Address: __________________________________________________________________________________________________________

Phone: ___________________________________

MD/DO/NP/PA Signature (required): _____________________________________________________________________________________
(Students requesting exemption from the meningitis vaccine for medical, religious, or other reasons, must read, sign and return this form)

Dear Parent/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. If your student has already received a meningitis vaccine, you can disregard this form. If the student has chosen not to receive the vaccine due to medical, religious, or other reason, the law states that a student may waive the vaccine after reading this educational information and carrying out careful deliberation. A student waiving the vaccine must read, sign and return this form before starting on campus in order to avoid issues with residential housing on campus.

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 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 to 18 to provide the best protection during the ages of highest risk. At least 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. The Center for Disease Control notes that adolescents ages 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/carryer. 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 five 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 all susceptible individuals. It does not protect against viral meningitis.

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

For more information, please feel free to contact Cohen Student Health Center at 814-824-2431, Monday-Friday 9am-4pm or contact your family physician.

Sincerely,

Judy Smith, Ph.D.

Judy Smith, Ph.D.
Executive Director of Wellness
***TO BE COMPLETED ONLY IF THE STUDENT DID NOT RECEIVE THE MENINGITIS VACCINE***

PLEASE PRINT

Student’s Name: _______________________________ Date of Birth: ________________

Home Address: _______________________________________________________________
                  Street                                         City                                         State                Zip

Home Telephone: ___________________________ Student Cell Phone: ______________________

PLEASE MARK THIS BOX 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)

Signature: __________________________________________Date:___________________
          (Physician)

☐ RELIGIOUS EXEMPTION: I, ______________________(Print Name) adhere to a religious belief whose teachings are opposed to such immunizations.

☐ OTHER: ____________________________________________________________________

Student Signature: __________________________________________Date: _______________
          (Parent/Guardian, if under 18 years old)