



POINT PARK UNIVERSITY

Student Health Center

201 Wood Street | Pittsburgh, Pennsylvania 15222

phone 412-392-3800 | fax 412-392-3801 | www.pointpark.edu

STUDENT HEALTH RECORD

Part One

TO THE STUDENT: Information you provide will have no effect upon your position at Point Park University. This information is confidential and will be used only if necessary by the STUDENT HEALTH CENTER as an aid to providing necessary health care while you are a student, and will not be released to anyone without your knowledge and consent. You will not be fully registered until the Student Health Center receives this completed form.

Please Print

NAME: LAST FIRST MIDDLE DATE OF BIRTH M() F() SEX

HOME ADDRESS: NO. AND STREET CITY/TOWN STATE ZIP CODE HOME PHONE

SOCIAL SECURITY NO. MARITAL STATUS COUNTRY OF ORIGIN COUNTRY OF CITIZENSHIP

MAJOR TERM ENTERING (MO/YEAR) STUDENT'S CELL PHONE NUMBER

LOCAL ADDRESS WHILE ATTENDING COLLEGE: NO. AND STREET CITY/TOWN STATE ZIP CODE

EMERGENCY CONTACT: (NAME & RELATIONSHIP) ADDRESS PHONE NO.

MEDICAL HISTORY

Do you have any health problems or concerns? (Example: asthma, diabetes, etc.) Yes No If yes, please explain:

Please list any major illness, surgery, or injuries you have had (include dates):

Do you take any medications regularly? Yes No If yes, please list:

Are you allergic to any medications or have any other known allergies? Yes No If yes, please explain:

Is there any other information that would be helpful in providing you with healthcare? (Include physical limitations.)

MEDICAL INSURANCE

Name of insurance company: Policy/Group Numbers:

Insurance company addresses (include street number, city, state and zip code)

Insurance company phone #: Name & relationship of policy holder:

STATEMENT & CONSENT * If you have a disability which hampers communications and/or mobility, please notify and provide documentation of disability to the Student Health Center in advance of your arrival so that we can make arrangements to assist you.* I give my permission for any diagnostic and/or therapeutic procedures as may be deemed necessary by the University professional medical staff. It is understood that I will assume all financial obligations involved which are not covered by the family health insurance plan.

Signature of Student

Signature of Parent or Guardian (if under 18 years of age)

Date

PART TWO ON OTHER SIDE (MUST be filled out.)



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Student Health Record

Part Two

*******Failure to submit proper immunization documentation will result in the student's ineligibility to register for classes.**

Name: _____
Last name First name Middle name

IMMUNIZATION RECORDS: ALL students born after January 1, 1957, are REQUIRED to provide documentation of having the following immunizations prior to entering Point Park University.

1. MMR (Measles, Mumps, Rubella) (Two doses are Mandatory)

Dose 1 given at age 12-15 months or later.....#1 _____ / _____
Month Year

Dose 2 given at age 4-6 years or later,
and at least one month after first dose.....#2 _____ / _____
Month Year

2. DTP (Tetanus, Diphtheria, Pertussis) (Basic series completed) _____ / _____
Month Year

3. Tuberculosis Skin Test (MUST be within the past year) _____ / _____ / _____ Result _____
If positive skin test, required Chest X-ray _____ / _____ / _____ Result _____

4. Meningitis Vaccine (REQUIRED for all resident students) _____ / _____ / _____
Must be within the last 5 years

Recommended Immunizations:

Tetanus Booster _____ / _____ / _____

Varicella (chicken pox) _____ / _____ / _____

Hepatitis B series _____ / _____ / _____

The above data **MUST** be verified by a physician's signature OR by the student presenting to the Student Health Center immunization documentation, which may include: baby records, clinic records, previous school records, military records (DD-214), etc.

Physician's Name _____ Physician's signature _____
(Please print)

Physician's address & phone number _____

Physician's Official Seal

Date _____