

Student Health Center

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 and use ink.

Last name First name Middle name Date of birth Gender

Home address: Number and street City/Town State Zip Code Home phone #

Marital Status Country of birth Country of citizenship

Major Term entering (Month/Year) Student's cell phone number

Local address while attending the University: Number and street City/Town State Zip code

EMERGENCY CONTACT: (Name & relationship) Complete Address Phone number

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 medication 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 phone #: _____ Name & relationship of policy holder: _____

STATEMENT AND 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 student is under 18 years of age)

Date

PART TWO ON OTHER SIDE (MUST be filled out)

Student Health Center

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 Day Year

Dose 2 given at 4-6 years or later,
and at least one month after the 1st dose#2 _____/_____/_____
Month Day Year

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

3. Tuberculosis skin test (MUST be within the past year) _____/_____/_____ **Result** _____

If positive TB test, chest X-Ray is required (provide copy of report) Date: _____/_____/_____

4. Meningitis Vaccine (REQUIRED for all resident students) Dose 1: _____/_____/_____
Revaccinate every 3-5 years if living on campus Dose 2: _____/_____/_____

Recommended Immunizations:

Tdap 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 _____

Date _____