

STUDENT MEDICAL REPORT FORM

This document is MANDATORY for all incoming students. Please send all forms to the health office prior to the deadline date. A failure to do so will result in an academic hold and the inability to register for classes. All information attained from the Student Medical Report Form is confidential and only viewed by the medical staff in the MyHealth@School office. The information in this document will not be released to anyone without consent. A consent to release medical information form must be signed by the student for the medical staff to speak with any other party about any medical care provided or any health history.

PLEASE RETURN ALL FORMS TO THE MyHealth@School office –201 Wood Street. Thayer Hall Ste. 203. Pittsburgh PA 15222

Term of Entry : Year 20_____	On Campus <input type="checkbox"/> Off Campus <input type="checkbox"/>	Fall Deadline : July 1 Spring Deadline : November 1
Fall <input type="checkbox"/> Spring <input type="checkbox"/>		

Student Demographics

Please complete all pages and print legibly

Last Name	First Name (official)	Middle Name
Preferred Name	DOB	Gender Identity
Student personal phone number	Student ID	
School Address (Please identify which dorm building)		
Home Address (City, State, Zip)	International? Yes <input type="checkbox"/> No <input type="checkbox"/> Country :	
Student Email address		
Student athlete : Yes <input type="checkbox"/> No <input type="checkbox"/> If so, what team?		
Did you turn in your form to the athletic dept? Yes <input type="checkbox"/> No <input type="checkbox"/>		

Primary Care Physician

Name	Phone #
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Emergency Contact

Name	Relationship
Phone Number	

Name	Relationship
Phone Number	

Health History (You may need to continue providing information on additional page)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Eye trouble			Tumors/cancer/cysts			Anxiety		
Ear trouble			Breathing problems/asthma			Depression		
Throat Problems			Stomach problems			Other mental health		
Diabetes			Weight/eating disorder			Head injury		
Skin trouble			Chronic migraines/headaches			Concussion		
Heart problems			Seasonal allergies			Date(s)		
Disease/injury of joints			Hearing difficulty			Cleared?		
Seizures			Insomnia					
Dizziness/fainting								

Do you have any allergies? Include medications, foods, other substances No Yes If yes please list : _____

Do you have any special needs with which the MyHealth@School or the University Counseling Center can assist you or that may require follow up? No Yes If yes please list : _____

Have you had any major illnesses (Medical, surgical, or psychiatric) in the past? No Yes If yes please list : _____

Do you take any medication regularly (prescription, over-the-counter, vitamins and/or herbal supplements)? No Yes If yes please list : _____

Any other information you would like to share with the nurse? No Yes If yes please list : _____

Consent :

I give my consent for medical care and/or emergency treatment while I am enrolled at Point Park University. Care will be determined by the judgement of the UPMC MyHealth@School medical staff. I agree to be responsible for any costs associated with any of the above-mentioned care which are not covered by my personal health insurance. I am aware that a copy of applicable HIPAA documents may be obtained by the student from the health center.

Student's Signature

Date

Signature of Parent or Guardian

(Only if student is under 18 years of age)