MyHealth Point Park

3rd Floor, Student Center
Phone 412-392-3800 Fax 412-392-3801

# 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 Point Park 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 MAIL ALL FORMS TO MYHEALTH POINT PARK – 201 Wood St., Pittsburgh, PA 15222.**
**OR EMAIL IN PDF FORM TO Studenthealth@pointpark.edu**

| Term of Entry : Year 20_____<br>Fall ☐ Spring ☐ | On Campus ☐ Off Campus ☐ | Fall Deadline : July 1<br>Spring Deadline : November 1 |
|---|---|---|

## 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 ☐ No ☐<br>Country : |
| Student Email address | | |
| Student athlete : Yes ☐ No ☐ If so, what team? | | |
| Did you turn in your form to the athletic dept? Yes ☐ No ☐ | | |

## Primary Care Physician

| Name | Phone # |
|---|---|

## Emergency Contact

| Name | Relationship |
|---|---|
| Phone Number | |

| Name | Relationship |
|---|---|
| Phone Number | |



REV 2/22

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## 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 Point Park 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 MyHealth Point Park 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)