Name _____

Immunization Record
All Injections are Required Prior to Registration

Part III. To be completed and signed by a Health Care Provider (Dates must include month and year).

Student's Date of Birth ___ ___ ___ (Month Day Year)

Required

A. **Tetanus-Diphtheria** (complete both lines)
1. ☐ Completed primary series of tetanus-diphtheria immunizations ..... ___ ___ ___ (Month Day Year)
2. ☐ Received tetanus-diphtheria booster **within the last 10 years** ..... ___ ___ ___ (Month Day Year)

B. **M.M.R. (Measles, Mumps, Rubella)** If given instead of individual immunizations, Two Doses REQUIRED AS SPECIFIED.
If before 12 months, does not count.
Complete both lines.
1. ☐ Dose 1- Immunized at 12 months or after and before 4 years..... ___ ___ ___ (Month Day Year)
2. ☐ Dose 2- Immunized at 4 years or later ..... ___ ___ ___ (Month Day Year)

If given as individual immunization, please list type and date ..... ___ ___ ___ (Month Day Year)

C. **Tuberculosis** - Check appropriate box. Test required **regardless** of prior BCG vaccine.
1. ☐ PPD (Mantoux) test **within the past year** (Tine or monovac not acceptable) _____ Reaction Result: ☐ Positive ☐ Negative

Placed.....Date ___ ___ ___ (Month Day Year) Read.....Date ___ ___ ___ (Month Day Year)

IF POSITIVE PPD, ATTACH STATEMENT OF TREATMENT FROM PHYSICIAN OR HEALTH DEPARTMENT

D. **Polio**
1. ☐ Completed primary series of polio immunizations..... ☐ Yes ☐ No

Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV

Last booster..... ___ ___ ___ (Month Day Year)

E. **Hepatitis B** Dose 1 and Dose 2 **required** prior to matriculation (Please send verification after **each** injection)
☐ Two dose Regimen (Given between 11-15 years of age) ☐ Three dose Regimen

Date of 1st injection ___ ___ ___ (Month Day Year) 2nd injection ___ ___ ___ (Month Day Year) 3rd injection ___ ___ ___ (Month Day Year)

F. **Meningitis Vaccine (REQUIRED)** ..... ___ ___ ___ (Month Day Year)

Recommended

G. **Hepatitis A**..... #1 ___ ___ ___ (Month Day Year) #2 ___ ___ ___ (Month Day Year)

H. **Varicella (if no previous Varicella disease)**..... #1 ___ ___ ___ (Month Day Year) #2 ___ ___ ___ (Month Day Year)

I. **Gardasil**..... #1 ___ ___ ___ (Month Day Year) #2 ___ ___ ___ (Month Day Year) #3 ___ ___ ___ (Month Day Year)

J. **Other** _____

HEALTH CARE PROVIDER (REQUIRED)

Name_____ Address _____

Signature _____ Phone (_____) _____

Allegheny College Prematriculation Health Status Report

This folder must be completed in its entirety prior to registering/attending classes.
Students with incomplete reports will not be allowed to register/attend class.

Last Name (Print) First Name Middle

Home Address (Number and Street) City or Town State Zip Code

Date of Birth Student Cell Phone

Parent/Guardian Name, and Address Home Telephone Number

Parent/Guardian Business Address Business Telephone

List of colleges you have attended, addresses, and dates Citizenship

Religion _____ S M Other

Marital Status Class you are entering

Home Physician _____ Telephone ( ) _____

Address _____

INSURANCE INFORMATION

Subscriber's SS# _____

Subscriber Name _____

Address _____

PLEASE ATTACH COPY OF INSURANCE CARD (FRONT AND BACK)

Group #/Plan Code

Precertification Required ☐ Yes ☐ No

Insurance Co. Name/Address/Phone _____

Agreement # or ID #

☐ Other Insurance (Attach copy of card)

1. I/We authorize the medical personnel of the College Health Center to treat surgical and/or medical conditions which may arise during the enrollment of the above named applicant; and
2. further authorize the medical personnel of the Meadville local hospitals to treat medical and surgical conditions which may be such a nature that cannot be handled at the College Heath Center. In the event of an emergency, every effort will be made to contact the parents for authorization of treatment; and
3. further authorize Meadville Medical Center to release any medical information to Allegheny College.
4. The Health Center is permitted to use/disclose your health information for the purpose of securing payment for the healthcare services provided you.
5. I have received and read carefully a copy of the HIPPA privacy regulations.

Applicant's Signature

Parent's or Guardian's Signature
(if applicant is under 18 years of age)

Social Security Number

Date

Return completed Health Status folder by July 8, 2011 to:

Director, Winslow Health Center
Allegheny College, Box 26
520 North Main Street
Meadville, PA 16335

WINSLOW HEALTH CENTER
ALLEGHENY COLLEGE
MEADVILLE, PENNSYLVANIA 16335

This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and consent.

PART I
REPORT OF MEDICAL HISTORY
To be completed by student and signed by health care provider.
Please complete this before going to your health care provider for examination.

FAMILY HISTORY

	Age	State of Health	Occupation	Age of Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease/ High Blood Pressure			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Seizure Disorder			

Personal History: Please Answer All Questions. Comment on all positive answers in space below or on an additional sheet.

HAVE YOU HAD	Yes	No		Yes	No		Yes	No		Yes	No
Scarlet Fever			Seizure Disorder			Pain/Pressure in Chest			Gallbladder Trouble or Gallstones		
Measles			Anxiety			Sports Injuries, etc.			Recurrent Diarrhea		
German Measles			Depression			Chronic Cough			Rupture, Hernia		
Mumps			Worry or Nervousness			Palpitations (heart)			Recent Gain or Loss of Weight		
Chicken Pox			Recurrent Headache			High or Low Blood Pressure			Dizziness, Fainting		
Malaria			Recurrent Colds			Rheumatic Fever or Heart Murmur			Weakness, Paralysis		
Gum or Tooth Trouble			Head Injury with Unconsciousness			Arthritis			Venereal Disease		
Sinusitis			Hay Fever			Anorexia			Urinary Infection		
Eye Trouble			Asthma			Bulimia			Frequent Urination		
Ear, Nose, Throat Trouble			Tuberculosis			Back Problems			Diabetes		
Surgery			Mono			Tumor, Cancer, Cyst			Thyroid Disorder		
Appendectomy			Allergy To:			Jaundice			**FEMALES ONLY**		
Tonsillectomy			Penicillin			Stomach or Intestinal Trouble			Irregular Periods		
Hernia Repair			Sulfa			Attention Deficit Disorder			Severe Cramps		
Other			Serum			Bipolar Disorder			Excess Flow		
			Foods (which)			Migraines			Pregnancy		
			Other			Other					

Please Note:
If you require any ongoing treatment, it is your responsibility to contact the Health Center at (814) 332-4355 or the Counseling Center staff at (814) 332-4368 to make arrangements.

	Yes	No
A. Has your physical activity been restricted during the past five years? (Give reasons and durations)		
B. Have you had difficulty with schools, studies, or teachers? (Give details)		
C. Have you had any illness or injury or been hospitalized other than already noted? (Give details)		
D. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years? (Other than routine checkups?)		
E. Medication, drugs, or other treatment within past 2 years (including Birth Control pills)		

REMARKS OR ADDITIONAL INFORMATION
(Use additional sheet if necessary)

Student Signature

Health Care Provider's Signature (Acknowledging Review)

WINSLOW HEALTH CENTER
ALLEGHENY COLLEGE
MEADVILLE, PENNSYLVANIA 16335

PART II
REPORT OF HEALTH EVALUATION
TO BE COMPLETED BY HEALTH CARE PROVIDER

TO THE EXAMINING PROVIDER: Please review the student's history and complete this form. Please comment on all positive answers. **THIS STUDENT HAS ELECTED TO ENROLL**. The information supplied will not affect his or her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for use by the professional staff of Allegheny College and will not be released without student consent.

Sex: M ☐ F ☐

Last Name First Middle

BP Height Inches Weight Lbs.

LIST DRUG ALLERGIES

Are there abnormalities of the following systems? Describe fully. Use additional sheet if needed.

	Yes	No
Head, Ears, Nose, or Throat		
Eyes		
Respiratory		
Cardiovascular		
Musculoskeletal		
Hernia		
Gastrointestinal		
Genitourinary		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Is there any ongoing medical treatment that should be continued while the student is attending Allegheny College, including counseling? ☐ Yes ☐ No Please explain.

Is there loss or seriously impaired function of any organ? ☐ Yes ☐ No

Physical Education requirement (PE, Intramurals, Other) Limited Explain _____

Health Care Provider's Signature _____ Address _____

Print Last Name _____

Date _____

Note: Please complete immunization record on following page