Gwynedd-Mercy College

FOR NURSING STUDENTS ONLY

MEDICAL HISTORY/PHYSICAL EXAMINATION RECORD

Please read form in its entirety and do not leave any blanks. Make a copy and keep for your own records. Faxed forms will not be accepted.

Complete and return all pages to:

Gwynedd-Mercy College
Campus Health Center
1325 Sumneytown Pike
PO Box 901
Gwynedd Valley, PA 19437-0901

Check all that apply:
_____ athlete
_____ resident
_____ nursing/allied health student
_____ international student
_____ none of above

Date of Entrance

Fall _____ Spring _____ Summer _____ Year _____

entering as: Fr _____ So _____ Jr _____ Sr _____

Expected date of graduation ____________________

Program of study ____________________

Student Information (please print)

Name ____________________

Social Security # ____________________

Date of Birth ____________________

Male _____ Female _____

Home Address ____________________
City State Zip Code

Home Phone # ____________________

Cell Phone # ____________________

Are you an American citizen? _____

If not, please list citizenship ____________________

Emergency Contact Information

Name ____________________

Relationship ____________________

Address ____________________
City State Zip Code

Home Phone # ____________________

Work Phone # ____________________

I hereby give permission to the student health center practitioners or to a physician of their choice, to prescribe necessary medication and/or perform treatments or operations necessary in the best interest of my health. I understand that my parents or guardians will be notified of any serious illness or injury at my request.

____
Signature of student Date

____
Signature of parent or guardian (if student is a minor) Date

Health Insurance Information

All full-time undergraduate and all international students are required to have health insurance. You will automatically be enrolled in the Student Health Insurance Plan unless you complete the following information and submit a waiver form to this office. For more information contact Campus Health at ext. 445 or 306.

Name of Insurance Company ____________________

Customer Service Phone number ____________________

Group Number ____________________

Name of Policy Holder ____________________

Identification Number ____________________

Prescription Plan? Yes _____ No _____ (check one)

FOR OFFICE USE ONLY

Received __________ Follow-up ____________________ Date Completed __________

To the student: You have been accepted to Gwynedd-Mercy College. Information you provide will not be used to influence your situation at the College; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and consent.

Report of Medical History

Please complete this before going to your health care provider for examination.

Name ____
Last First Middle

Social Security # ______________________________

Family History

	Age	State of Health	Occupation	Age/Cause of Death
Father				
Mother				
Brother(s)				
Sister(s)				

	Yes	No	Relationship
Diabetes			
Heart Disease/Stroke/High Blood Pressure			
Cancer			
Asthma/Allergies			
Tuberculosis			
Alcohol/Drug Problem			
Depression			

Personal History - Please answer all questions - Please comment on all positive answers.

Have you had?	Yes	No
Chicken Pox		
Measles		
German Measles		
Mumps		
Mononucleosis		
More than 10 lb. weight gain or loss in past year		
Females: menstrual problems		

Have you had?	Yes	No
Dental problems		
Eye problems		
Ear, nose, throat problems		
Asthma		
Allergies		
Penicillin allergy		
Sulfa allergy		

Have you had?	Yes	No
Head injury or concussion		
Epilepsy/ seizures		
Migraines		
Anxiety or depression		
Sleep difficulty		
Eating disorder		
Alcohol/drug problem		
Learning disability		

Have you had?	Yes	No
Disease/injury of joints		
Back problems		
Heart trouble/high blood pressure		
Stomach/intestinal problems		
Liver or kidney problems		
Skin problems		
Tumors or cysts		
Cancer		
Diabetes		

	Yes	No
Do you drink alcohol?		
Do you smoke cigarettes, cigars or use smokeless tobacco?		
Do you take medications on a regular basis? (List)		
Has your physical activity been restricted during the past five years? (Explain)		
Have you received treatment or counseling for alcohol or drug abuse, an eating disorder, depression or any other emotional problem? (Explain) Have you been hospitalized for any of the above?		
Have you had any significant illness or injury for which your have been treated or hospitalized other than already mentioned? (Explain)		
Do you have any questions in regard to your health, family history, or other matters?		

______________________________ ______________________________ ______________
Student's Signature Health Care Provider's Signature (Acknowledging Review) Date

Remarks or Additional Information (Use additional sheet if necessary):

Physical Examination

TO THE EXAMINER: PLEASE REVIEW THE STUDENT'S HISTORY AND COMPLETE THE PHYSICAL EXAMINATION AND IMMUNIZATION RECORD. PLEASE COMMENT ON ALL POSITIVE ANSWERS.

Name ______________________________ Allergies ____________________
Last First Middle

Sex: Male ______ Female ______ ____________________

Blood Pressure ______________ Pulse ______ Height ______ inches Weight ______ lbs.

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

Please comment on all positive findings.

	Yes	No
Head, Ears, Nose, Throat		
Eyes		
Respiratory		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurologic		
Skin		
Psychiatric		

Comments:

Is the patient now under treatment for any medical or emotional condition? Yes ______ No ______

Is the patient taking any medication on a regular basis? Yes ______ No ______

If yes, list medications ______________________________

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

Recommendations for physical activity:

(Intercollegiate Athletics, Intramurals, Physical Education) Unlimited ______ Limited ______

Explain ______________________________

Do you have any further recommendations for the care of this student? Yes ______ No ______

Explain ______________________________

Health Care Provider ______________________________

Name ______________________________

Address ______________________________

Phone # ______________________________

Signature ______________________________ Date ______________________________

Name ____

To be completed not more than six months prior to classes beginning.

THE FOLLOWING BLOOD WORK IS MANDATORY (PLEASE ATTACH TITER RESULTS FOR ITEMS 1-5)

1. **RUBELLA (German Measles): Disease history is not acceptable as proof of immunity.**
   A Rubella IgG Titer (Blood Test) is required and a copy of the lab report must be attached to this form. If the blood shows that the student is not immune, the student must be re-immunized. If test indicates susceptibility, re immunization is required: Date of re-immunization: ______________
2. **RUBEOLA (Measles): Disease history is not acceptable as proof of immunity.**
   A Rubeola IgG Titer (Blood Test) is required and a copy of the lab report must be attached to this form. If the blood shows that the student is not immune, the student must be re-immunized. If test indicates susceptibility, re-immunization is required: Date of re-immunization: ______________
3. **MUMPS: Disease history is not acceptable as proof of immunity.**
   A Mumps IgG Titer (Blood Test) is required and a copy of the lab report must be attached to this form. If the blood shows that the student is not immune, the student must be re-immunized. If test indicates susceptibility, re-immunization is required: Date of re-immunization: ______________
4. **VARICELLA: Disease history is not acceptable as proof of immunity.**
   A Varicella IgG Titer (Blood Test) is required and a copy of the lab report must be attached to this form. If the blood shows that the student is not immune, the student must be re-immunized. If test indicates susceptibility, re-immunization is required: Date of re-immunization: ______________
5. **HEPATITIS B VACCINE:** All students must have begun the Hepatitis B Vaccine series prior to the start of classes. The series consists of three injections. An initial injection, followed by the second injection one month later, followed by the third injection five months after the second.

Dose #1: Date of vaccination: ________
Dose #2: Date of vaccination: ________
Dose #3: Date of vaccination: ________

All students who have already completed the Hepatitis B vaccine series are required to have a Hepatitis B surface antibody titer (Blood Test) to confirm immunity. A copy of the lab report must be attached to this form. For students who are just beginning the Hepatitis B series, a titer is required one month after completion of the series.

DIPHTHERIA AND TETANUS TOXOID: Booster shot within the past 10 years: Date: ____________________

POLIO VIRUS: Did the student complete the childhood polio vaccine series? Yes _____ No ____
If yes, on what date was the series completed? Date: ____________________
If no or unsure, an adult booster is required. Booster Date: ______________

PPD: A BASELINE TWO-STEP PPD skin test is required:
Initial PPD skin test: Date: ______________ Result: __________________ mm of induration.
If negative, 2nd PPD skin test: Date: ______________ Result: __________________ mm of induration.
(Two PPD skin tests are required; and according to CDC guidelines, should be 1-3 weeks apart)
Students who have completed a two-step PPD test in the past, require an annual single-step PPD.
Annual PPD skin test: Date:______________ Result: __________________ mm of induration.

Positive PPD: (Only for those who have had a positive PPD skin test)
- Date of positive test: ______________
- Attach a copy of the result of a chest x-ray obtained since the positive TB test.
- Attach healthcare provider documentation of any TB treatment, history of BCG vaccination, and absence of TB symptoms.

Meningitis Information Response – Required of all resident students (**Check either #1 or #2**)

1.________ I have had the meningococcal meningitis immunization.

2.________ I have read, or have had explained to me, the information regarding meningococcal meningitis disease.
I understand the risks of not receiving the vaccine and have decided that I will **NOT** obtain immunization against meningococcal meningitis disease.

Signature of Student Required: ____
(Or Parent/guardian if student is under age 18)

URINE DRUG SCREEN
Attach copy of laboratory report for Urine Drug Screen which includes testing for ALL of the following substances:

1. amphetamines
2. barbiturates
3. benzodiazepines
4. cannabinoids
5. cocaine
6. opiates
7. phencyclidine

Clinician's initials that information above is correct ____________

[1] Catagories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone $\geq$15 mg/d for $\geq$1 month) or other immunosuppressive disorders.