

Dear Student:

Congratulations and welcome to East Stroudsburg University. The University Health Services staff is already beginning to plan for your arrival and is looking forward to meeting you in the near future. We have a variety of services to offer you including quality affordable health care, and health promotion/ wellness opportunities. Listed below is some important information for your consideration:

- Health Services **strongly recommends** that you submit the ***Report of Medical History*** form, which includes your immunization history prior to entrance to the university. There are many areas of study that will **require** this information during your course of study including education, the health sciences, (such as nursing, psychology, speech and hearing, athletic training, and exercise science), and many internships and academic placements. We recommend that you gather this information and submit it before you begin to avoid postponements in your class schedules.
- It is very important for **parents of students who are less than 18 years old** complete page one of the *Report of Medical History* form and **sign the consent for treatment**.
- Pennsylvania law requires **all students residing in university owned housing to have received meningitis vaccination or be informed of the risks and benefits of the vaccine**. This information is to be completed when you submit your housing application.
- All **intercollegiate athletes are required** to submit the physical examination contained in the *Report of Medical History form* **due July 21 for Fall semester, or January 1 for Spring Semester**. The physical exam must be completed within 6 months of the start date of your sport.
- All **international students are required** to submit the ***Report of Medical History*** form with up to date immunizations prior to entrance to the university (including Measles, Mumps, Rubella, Tetanus/Diphtheria, and Tuberculosis testing or negative chest x-ray within the past year). **Immunization information must be in English**. It is important that you complete the form while you are in your home country as medical services in the USA can be very costly and may be difficult for you to obtain here. The *Report of Medical History* form is **due July 21 for Fall semester, or January 1 for Spring Semester**.
- The *Report of Medical History* Form, information about affordable health insurance, and information about meningitis vaccination can be downloaded at [www.esu.edu/healthservices](http://www.esu.edu/healthservices)

If you have any questions or concerns, please feel free to call us at 570-422-3553 or visit the Flagler Metzgar Health Center. We look forward to taking care of your health care needs

Sincerely,

*The University Health Services Staff*

**REPORT OF MEDICAL HISTORY****Mandatory for International Students****Other Students:** May be required for class scheduling of some academic majors i.e. Education, Health Sciences, other, etc.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Student ID \_\_\_\_\_

Home Address \_\_\_\_\_ ☐ Male ☐ Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Student Cell Phone# \_\_\_\_\_ Home Phone # \_\_\_\_\_ Birthday \_\_\_\_\_

Parent/Guardian/Emergency Contact Name \_\_\_\_\_ Contact Phone # \_\_\_\_\_

**HEALTH INSURANCE (please provide a copy of the front and back of insurance card)**

Insurance Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ Group Number \_\_\_\_\_

**ENROLLMENT STATUS** (check all that apply)

☐ Undergrad ☐ Graduate ☐ Transfer ☐ International ☐ Exchange ☐ Other \_\_\_\_\_

**MEDICAL HISTORY**

N/A \_\_\_\_\_

Allergies to Medications/ Seasonal \_\_\_\_\_

Diseases/Surgeries/Injuries/Chickenpox: \_\_\_\_\_

Daily Medications \_\_\_\_\_

Have you ever been diagnosed with depression/anxiety/or other psychological illness? (Please explain on separate sheet)

Other: \_\_\_\_\_

**MEDICAL RELEASE STATEMENT**

*By signing this, I affirm that all information in this document is correct and complete. I also agree to inform the Student Health Center of any changes in my health or in the information on this form. I grant permission to the staff of University Health Services to render any treatment necessary. I understand under certain circumstances or emergencies I may be referred to a hospital, diagnostic testing, or a medical specialist for diagnoses and /or treatment. Costs incurred for these services are the responsibility of the patient and I will be responsible for all bills incurred that are not covered by my health insurance carrier.*

*I authorize release of my medical records and information to my insurance company for the purpose of reimbursement.*

*I authorize the release of my medical records and information to a licensed physician, hospital, clinic, other medical personnel, including University Athletic Training Services and Counseling and Psychological Services, in the event of an emergency or continuation of care. This authorization shall remain in effect while enrolled at East Stroudsburg University or written withdrawal of consent is received at University Health Services.*

\*\*\*

Student Signature

(or Parent/Guardian if student is under 18 yrs)

Date

Last Name

First Name

Student ID#

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Mandatory for International Students (other students may be required for class scheduling of some academic majors, i.e., Education, Health Sciences, other, etc.)

Attach official documentation (in English) from a school, medical records, or have your physician complete this form

### REQUIRED IMMUNIZATIONS:

\*\* May attach official copies of reactive Titer test results, in lieu of vaccination dates, for MMR and Tetanus.

1. MMR (MEASLES/MUMPS/RUBELLA) Students born before JANUARY 1956 are exempt from MMR vaccinations

Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_

2. TETANUS / TDAP (within past 10 years) Date: \_\_\_\_\_

3. TUBERCULOSIS Screening:

TB testing is **REQUIRED** for ☐ International Students, ☐ Non-USA born students, ☐ students who have been exposed to tuberculosis or are high risk

TB PPD TEST done within past year: DATE GIVEN: \_\_\_\_\_ DATE READ: \_\_\_\_\_ RESULTS: \_\_\_\_\_ mm Negative \_\_\_\_\_ mm Positive

**OR** QUANTIFERON Test DATE: \_\_\_\_\_ Results: \_\_\_\_\_ ☐ attach copy of lab results

☐ Attach a Copy of Report of Chest X-ray for positive PPD or positive Quantiferon test DATE: \_\_\_\_\_

☐ Treatment received for positive TB screening/CXR- DESCRIBE \_\_\_\_\_

4. MENINGOCOCCAL QUADRIVALENT A, C, Y, W-135: (after age 16) ☐ YES Date: \_\_\_\_\_ ☐ NO  
(Required if living in University owned housing)

☐ MENINGITIS WAIVER: Student has been advised of the risks associated with meningococcal disease, the availability/effectiveness of the vaccination, and has decided not to receive the vaccine, or has received the vaccine before age 16.

Student Signature

(Parent/Legal guardian if student is under 18 yrs)

DATE

### RECOMMENDED IMMUNIZATIONS:

5. POLIO Series completed Date: \_\_\_\_\_

6. VARICELLA: (optional) Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ OR Date of Disease: \_\_\_\_\_

7. HPV Vaccine (optional) Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

8. HEPATITIS B (Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_)

**REQUIRED PHYSICIAN'S SIGNATURE** (stamp not accepted)

(If completed by PAC or NP include name of Physician Association)

DATE

\*\*\* Print Physician's Name \_\_\_\_\_ \*\*\* License # \_\_\_\_\_ Telephone # \_\_\_\_\_

City

State

Zip Code

**East Stroudsburg University  
Immunization Exemption**

(International Students may only be exempted from Immunizations for a medical contraindication)

\_\_\_\_\_  
**Student Name (Print)**

\_\_\_\_\_  
**Student ID#**

*To be completed and signed by a Medical Care Provider and the Student*

**CHECK ONE**

1. \_\_\_\_\_ **PERMANENT** medical contraindication (state vaccine): \_\_\_\_\_

Explanation \_\_\_\_\_

2. \_\_\_\_\_ **TEMPORARY** medical contraindication (state vaccine): \_\_\_\_\_

Explanation \_\_\_\_\_

Anticipated Date of End of Exclusion \_\_\_\_\_

3. \_\_\_\_\_ **DECLINED VACCINE** for personal or religious reasons:

The Student has been advised of the risks, the effectiveness, and availability of vaccines and **has decided not to receive the vaccine(s) checked below:**

<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Tetanus/Diphtheria	<input type="checkbox"/> Pertussis	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
<input type="checkbox"/> Meningococcal Quadrivalent	<b>A, C, Y, W-135: (after age 16)</b>		<input type="checkbox"/> Varicella		

☐ Tuberculosis testing:.

(Non-US born students, International students, and high risk students may not be exempt. TB testing is required for health and education related majors.) [http://www.acha.org/Publications/docs/ACHA\\_Tuberculosis\\_Screening\\_Apr2011.pdf](http://www.acha.org/Publications/docs/ACHA_Tuberculosis_Screening_Apr2011.pdf)

**I am unable to comply with the East Stroudsburg University Immunization Policy as set forth in ESU-SA-2101-017. I understand that if an outbreak of communicable disease occurs I may be required to leave campus immediately for a period of time determined by the University. This may negate my attending classes for this period of time.**

\_\_\_\_\_  
**\*\* Student Signature (REQUIRED)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**\*\* Signature of MD, NP, PAC, NP (Stamp not accepted)**  
If completed by PAC or NP print name of Physician Affiliation

\_\_\_\_\_  
**License #**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Print Name of Medical Provider

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip