Student Health Services

200 East Brown Street
East Stroudsburg, PA 18301

272-762-4378 (Phone)
570-420-2447 (Fax)

Dear Student:

Congratulations and welcome to East Stroudsburg University. The Student Health Services staff and Lehigh Valley Health Network-Pocono Express Care 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 *I* 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 include 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 I listory* 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 otthe 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 1for 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 1for Spring Semester.

If you have any questions or concerns, please feel free to call us at 272-762-4378 or visit the Student Health Services.

We look forward to taking care of your health care needs.

Sincerely,

The Student Health Services Staff

RETURN FORM TO: Student Health Services
200 East Brown Street, East Stroudsburg, PA 18301

272-762-4378 (Phone)
570-420-2447 (Fax)

# 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_____ **D** Male **D** 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)

**D** Undergrad **D** Graduate **D** Transfer **D** International **D** Exchange **D** Other_____

**MEDICAL HISTORY**

N/A_____

Allergies to Mediations/ 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 Student 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 Student Health Services.*

_____ _____

*Student Signature* ***(or Parent/Guardian if student is under 18yrs)*** *Date*

Last Name First Name Student ID



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 I MUMPS I RUBELLA) Students born before JANUARY 1956 are exempt from MMR vaccinations*

Date: #1_____ #2_____

*2. TETANUS I TOAP (within past 10 years) Oate:_____*

*3. TUBERCULOSIS Screening:*

*TBff!J.S.t.iJJ.OisREflJJIREDFor O International Students, O Non-USA born students, O students who have been exposed to tuberculosis or are high risk*

*TBPPO TEST done within past year: OATE GIVEN: OATE READ: _____ RESULTS: _____ mm Negative _____ mm Positive*

OR QUANTIFERON Test *OATE: _____ Results: _____ O attach copy of tab results*

O *Attach Coov of Reporl of Chest X-rav tor positive PPD or positive Quantiferon test DATE: _____*

O *Treatment received tor positive TB screening! CXR- DESCRIBE. _____*

*4. MENINGOCOCCAL QUAORIVAVALENTA, C, Y, W-135: (after age 16)* 0 YES Date:-------- ONO

*(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 ta receive the vaccine, or has received the vaccine before age 16.*

_____ _____

*Student Signature* *(Parent/Legal Guardian if student is under 18yrs)* *OATE*

## *RECOMMENDED IMMUNIZATIONS:*

*5. POLIO Series completed Date: _____*

*6. VAR/CELLA: (optional) Dates:* #1_____ #2_____ OR Date of Disease: _____

*7. HPV Vaccine: (optional) Dates: #1* #2_____ #3_____

*8. HEPATITIS 8: Oates:* #1 #2 #3_____

_____ _____

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

*(if completed by PAC or NP include name of Pfiysician Association)*

**·*Print Physician's Name - —————————— ***License #* _____ *Telep/lone #·-* _____

_____ _____

*City* *State* *Zip Code*

# East Stroudsburg University

## Meningitis Information

June 26, 2002, Pennsylvania passed legislation (Senate Bill 955) requiring all students living in university residence hall/ housing, to either have the vaccine or sign a declination statement after having received information concerning the benefits of receiving the meningitis vaccine.
College students are at increased risk for meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis. Infact, freshmen living inresidence halls arefoundtohaveasix-fold increased riskforthe disease. The American College Health Association (ACHA) and the Center for Disease Control and Protection (CDC) recommend that college students, particularly students living in residence halls, learn more about meningitis and vaccination. At least 70% of all cases of meningococcal disease in college students are vaccine preventable.

- What is meningococcal meningitis? Meningitis is rare but when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.
- How is iisoread? Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
- WhWe the fillmptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
- Who is at risk? Certain college students, particularly freshmen who live in residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates should also consider vaccination to reduce their risk for the disease.
- Can meningitis be prevented? A safe and effective vaccine is available to aid in protection against four of the five most common strains of the disease (NC/Y/W-135). Adverse reactions to the meningitis vaccine are mild and infrequent, consisting primarily of redness and pain at the injection site and in rare cases, a fever. As with any vaccine, vaccination against meningitis may not protect 100 percent ot all susceptible individuals. ***The vaccine does not protect against viral meningitis.***
- Whv is a booster shot being recommended now? When MCV4 was first recommended for adolescents in 2005, the expectation was that protection would last for 10 years; however, currently available data suggest it wanes in most adolescents within 5 years. Based on that information, a single dose at the recommended age of 11 or 12 years may not offer protection through the adolescent years at which risk for meningococcal infection is highest (16 through 21 years of age). If we didn't recommend a booster dose, adolescents at highest risk would not be well protected.

For more information: to learn more about meningitis and the vaccine, visit the Student Health Center or call 272-762-4378. You can also visit the websites of the Centers for Disease Control and Prevention (CDC). https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html and the American College Health Association, www.acha.org. Contact your family physician to find available vaccination centers.

# East Stroudsburg University
# Immunization Exemption

(International Students may only be exempted from Immunizations for 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:

O Hepatitis B D Tetanus/Diphtheria O Pertussis o Measles 0 Mumps O Rubella
O Meningococcal Quadrivalent *A, C, Y, W-135:* (after age 16) O Varicella

o 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 major.) http Uwww ach ora/Publications/docs/ACHA Tuberculosis Screening Apr2011.pdf

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

_____
** Student Signature (REQUIRED) Date

_____
"'* Signature of MD, NP, PAC, NP (Stamp not accepted) License# Date
If completed by PAC or NP print name of Physician Affiliation

_____
Print Name of Medical Provider

_____
Street Address City State Zip