



Dear Warrior:

Congratulations and welcome to East Stroudsburg University. The University Health Services staff at Lehigh Valley Hospital Pocono 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 follow-up and submission:

- Health Services **requires** all new full-time undergraduate students to 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 require that you gather this information and submit it before you begin to *avoid* postponements in your class schedules.
- It is very important for **parents/guardians 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. To learn the risks and benefits, please visit: <https://bit.ly/355Gyde>. This information is to be completed when you submit your housing application.
- Included in this packet is a Consent for Transfer of Information. It must be completed and sent with your *Report of Medical History* form. ESU Student Health Center were outsourced to Lehigh Valley Hospital-Pocono for student ambulatory health services. This was done to increase service hours including evening, weekends and remote site access. However, ESU staff still collects and monitors the submission of your *Report of Medical History* Form. Once the form is received, it is transferred to the ESU Health Center at Lehigh Valley Hospital-Pocono, where your individual electronic health record is created.
- 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 U.S.A. can be very costly and may be difficult for you to obtain here.
- The *Report of Medical History* form is **due August 1 for Fall Semester, or January 1 for Spring Semester. It can be mailed to: Donna Shepherd, 036 Sycamore Suites, 200 Prospect Street, East Stroudsburg, PA 18301, or emailed to [dshepherd@esu.edu](mailto:dshepherd@esu.edu). It can also be faxed to 570-422-3731.**
- The *Report of Medical History* Form also can be downloaded at **[www.esu.edu/health-and-wellness/express-care.cfm](http://www.esu.edu/health-and-wellness/express-care.cfm)**

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

Sincerely,

**The East Stroudsburg Health and Wellness Team**

Updated: 6/30/2021

**[esu.edu/health-and-wellness/express-care.cfm](http://esu.edu/health-and-wellness/express-care.cfm)  
570-422-3553 • (Fax) 570-422-3731**

## REPORT OF MEDICAL HISTORY

### Mandatory for All New Full Time Undergraduate Students

Last Name _____	First Name _____	Middle Initial _____	Student ID _____
Home Address _____			<input type="checkbox"/> Male <input type="checkbox"/> 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)*

Undergraduate  Graduate  Transfer  International  Exchange  Other

### **MEDICAL HISTORY**

N/A \_\_\_\_\_  
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 the information on this form. I grant permission to the staff of the Health and Wellness Center to render any treatment necessary. I understand under certain circumstances or emergencies I may be referred to a hospital, for diagnostic testing, or to 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 years)

\_\_\_\_\_  
Date

Last Name

First Name

Student ID #

**Mandatory for International 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

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

Treatment received for positive TB screening/Chest-X-ray DESCRIBE \_\_\_\_\_

4. MENINGOCOCCAL QUADRIVALENT A, C, Y, W-135: (average 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 years)

\_\_\_\_\_  
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 \_\_\_\_\_

9. COVID-19 (OPTIONAL) Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ (if applicable)

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

\_\_\_\_\_  
Date

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

Physician Name: \_\_\_\_\_ License # \_\_\_\_\_ Telephone # \_\_\_\_\_

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

# 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:

Hepatitis B       Tetanus/Diphtheria       Pertussis       Measles       Mumps       Rubella

Meningococcal Quadrivalent A, C, Y, W-135: (*average age 16*)       Varicella

Tuberculosis testing:

(Non-U.S. born students, international students, and high risk students may not be exempt. TB testing is required for health and education related majors.) <https://bit.ly/3iuhrbT>

**I am unable to comply with the East Stroudsburg University Immunization Policy as set forth in ESU-2010-13-A.**

**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



# EAST STROUDSBURG UNIVERSITY

## Health and Wellness

Lower Level Sycamore Suites  
200 Prospect Street  
East Stroudsburg, PA 18301-2999  
570-422-3553

# CONSENT FOR TRANSFER OF INFORMATION

<b>STUDENT NAME:</b>	<b>STUDENT I.D. #:</b>
<b>DATE OF BIRTH:</b>	<b>CELL PHONE #:</b>

I, \_\_\_\_\_, do hereby consent to and authorize East Stroudsburg University Health Services, 200 Prospect Street, East Stroudsburg, PA 18301 to *disclose* to:

<b>NAME OF HOSPITAL:</b> Lehigh Valley Health Network – Pocono
<b>ATTENTION:</b> Student Health Services
<b>TELEPHONE#:</b> 272-762-4378
<b>ADDRESS:</b> 200 East Brown Street, East Stroudsburg, PA 18301
<b>FOR THE PURPOSE OF:</b> Provision of health services and continuity of care during enrollment at ESU

Information from medical records relating to my identity, diagnosis, prognosis, or treatment listed in my *Report of Medical History* form. However, I do not give permission for any other use or disclosure of this information.

I understand that my record will include my medical history and physical exam information. If previously seen in the ESU Health Center, it may also contain discharge summary/instructions, athletic physical information if applicable, psychological, psychiatric, lab results and other procedural follow-up reports.

I have read and understand the nature of this release.

**DATE:** \_\_\_\_\_

**STUDENT NAME:** \_\_\_\_\_

**WITNESS NAME:** \_\_\_\_\_

*(Parent/Guardian must witness/approve if the student is under 18 years of age)*

**PLEASE RETURN WITH YOUR REPORT OF MEDICAL HISTORY FORM TO:**

Ms. Donna Shepherd  
 East Stroudsburg University  
 036 Sycamore Suites  
 200 Prospect Street  
 East Stroudsburg, PA 18301  
 dshepherd@esu.edu  
 570-422-3553