East Stroudsburg University of Pennsylvania
University Health Services
Telephone (570) 422-3553
Fax (570) 422-3731

RETURN FORM TO:
University Health Services
Flagler-Metzgar Center
East Stroudsburg University
East Stroudsburg, PA 18301-2999

REPORT OF MEDICAL HISTORY

(**Required Form**: Please complete and return to the University Health Services –(***FORM WILL BE RETURNED TO YOU IF INCOMPLETE***)

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 ❑ On-Campus ❑ Off-Campus ❑ International ❑ ❑ Transfer

MEDICAL HISTORY

N/A_____

Allergies to Medications_____

Diseases/Surgeries/Injuries/Chickenpox/Varicella Vaccine:_____

Daily Medications_____

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

Other:_____

INTERCOLLEGIATE ATHLETES AND CHEERLEADERS – *(Indicate which sport(s) you will be participating in. (check all that apply)*

❑ *N/A* ❑ *Baseball* ❑ *Basketball* ❑ *Cheerleading* ❑ *Cross-Country* ❑ *Field Hockey* ❑ *Football* ❑ *Golf* ❑ *Lacrosse*
❑ *Soccer* ❑ *Swimming* ❑ *Softball* ❑ *Tennis* ❑ *Volley Ball* ❑ *Wrestling* ❑ *Track & Field*

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*

East Stroudsburg University of Pennsylvania
Physical Examination – Immunization Record
(This page must be completed and signed by an M.D., D.O., P.A., N.P.)
Must be completed within the past 12 months to be valid / past 6 Months for Athletics

Student Name (Last, First, Middle Initial) _____ Student ID #_____
Corrected vision ❑ Yes ❑No Pupils ❑ Equal ❑ Unequal Vision: R 20/_____ L 20/_____
B/P_____ Pulse _____ Height_____ Weight_____

(Please include a separate sheet of paper to explain the status of any chronic medical or physical condition)

	NORMAL	REMARKS		NORMAL	REMARKS
HEENT	❑	_____	*GENITOURINARY SYSTEM*	❑	_____
HEART	❑	_____	*ENDOCRINE SYSTEM*	❑	_____
CHEST	❑	_____	*NERVOUS SYSTEM*	❑	_____
ABDOMEN	❑	_____	*SEASONAL ALLERGIES*	❑	_____
MUSCULOSKELETAL	❑	_____	*DEPRESSION/ANXIETY*	❑	_____
BACK/SPINE	❑	_____	*OTHER PSYCHOLOGICAL*		
SKIN	❑	_____	*DISORDERS*	❑	_____
NEUROLOGICAL	❑	_____	*OTHER*	❑	_____

Physical Activity □ *Unlimited* ❑ _____
Describe _____

Conditions requiring clearance before intercollegiate athletic participation include, but are not limited to the following: anaphylaxis, instability, bleeding disorders, hypertension, congenital heart disease, dysrthythmia, mitral valve prolapsed, heart murmur, cerebral palsy, diabetes mellitus, eating disorder, heat illness history, one kidney athletes, hepatomegaly, splenomegaly, malignancy, seizure disorder, marfan syndrome, repeated concussion history, organ transplant recipient, cystic fibrosis, sickle cell disease, one-eyed athletes or vision greater than 20/40 in one eye.* ***REQUIRED FOR PARTICIPATON IN INTERCOLLEGIATE ATHLETICS This physical examination must be completed within 6 months prior to the team participation start date.

REQUIRED IMMUNIZATIONS

□ ***Copy of Titer test results in lieu of vaccination dates must be attached. Students born before 1956 are exempt from MMR vaccinations***

1. MMR *(MEASLES/MUMPS/RUBELLA)* ***DOSE 1****- DATE:*_____ ***DOSE 2****-DATE:*_____

2. TETANUS / TDAP *DATE: (WITHIN 10 YEARS)* _____

3. Hepatitis B ***#1*** _____ ***#2*** _____ ***#3*** _____

4. TB TEST Within past year: ***DATE GIVEN:*** _____ ***DATE READ:*** _____ ***RESULTS:*** _____ ***mm Negative*** _____ ***mm Positive***

□ ***Copy of Report of Chest X-ray*** *is required for positive PPD (or if PPD not done) Date:*_____

□***Treatment received for positive PPD/CXR- DESCRIBE:***_____

5. COMPLETED PRIMARY SERIES OF POLIO IMMUNIZATIONS ON (DATE):_____

6. MENINGITIS VACCINE *:* Date: _____ (Age 16 or older)

□ ***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.*

_____ _____
Student Signature ***(Parent/Legal guardian if student is under 18 yrs)*** ***DATE***

This student □is □ is not medically cleared to participate in intercollegiate athletics.

_____ _____
PHYSICIAN'S SIGNATURE (stamp not accepted) ***DATE of Immunization verification and Physical Examination***

(If completed by PAC or NP include name of Physician Association) *(Physical must be completed within 6 months prior to any athletic participation)*

***** ***Print Physician's Name*** _____ ***** ***License #***_____ ***Telephone #***_____

_____
City or Town ***State*** ***Zip Code***