USciences University of the Sciences | Student Health and Counseling (SHAC)
Box 23; 600 South 43rd Street; Philadelphia PA 19104
Phone: (215) 596-8980

2017-2018 STUDENT HEALTH RECORD
SUMMER/FALL 2017 DUE DATE:
AUGUST 4, 2017

Your Student Health Record is to be completed and submitted by uploading documents to the Student Health Services Portal by the due date of August 4, 2017. Students submitting forms after the due date will incur a $25 late fee, applied to their tuition, and placed on a Health Hold. Health Holds prevent students from registering for classes, viewing final grades and, dropping and adding classes.

HEALTH RECORD SECTIONS TO BE COMPLETED BY THE STUDENT	HEALTH RECORD SECTIONS TO BE COMPLETED BY HEALTH CARE PROVIDER
Personal Health History – Online	**Part IV** –Evaluation & Physical Exam (pages 5-7)
Part I – Demographics (page 2)	**Part V** – Immunization Record (page 8)
Part II – Meningococcal Vaccine (page 3)	**Part VI** – Surface Antibody Titers (page 9)
Part III – Permission to Release Records *(*page 4)	
Immunization Record – Online	

Your completed Health Record and any laboratory results must be uploaded to the Student Health Portal at: shac.usciences.edu

Do not submit these specific Health Record documents to your academic or athletic department. Completing Student Health Record satisfies the University's Health Policy. Health Record Documents **must be** submitted to Student Health Services by uploading all forms to the Web Portal. Do Not mail or fax the Health Record Documents.

- Your academic or athletic department may require similar or additional health information. Submission of the Student Health Record to Student Health Services may not satisfy your academic or athletic department requirements.

- Completing section III will give Student Health Services permission to release your records, if requested, to your academic department.

If you have questions or concerns about the Health Record, Web Portal, deadlines or documents please contact Student Health Services for guidance at 215-596-8980.

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PART I – DEMOGRAPHICS

ALL QUESTIONS ON THIS PAGE ARE REQUIRED. PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Name of Student: _____
Last Name First Name Middle Name

USciences Student ID Number: _____ **Date of Birth:** _____ **Sex:** _____

Academic Level: ☐ Undergraduate ☐ Graduate ☐ Post-Baccalaureate Health Professional

Major: ☐ Pharm D ☐ OT ☐ PT ☐ PA ☐ Other: _____

Home Address in U.S.: _____
Number and Street

_____
City State Zip Code

University Student Housing: ☐ Off-campus/Commuter ☐ On-Campus

Off-Campus Local Address: _____
Number and Street

_____
City State Zip Code

Residence Hall: ☐ Goodman ☐ Wilson ☐ Osol ☐ Alexandria

Cell Phone Number: _____ **Email Address:** _____

Place of Birth: _____
City State Country

In case of emergency, contact: _____

Relationship: _____ **Telephone Number:** _____

Address: _____
Number and Street

_____
City State Zip Code

Last Name	First Name	Student ID	Date of Birth

PART II – MENINGOCOCCAL VACCINE WAIVER

TO BE COMPLETED BY STUDENT

THIS WAIVER IS NOT APPLICABLE TO STUDENTS RESIDING IN UNIVERSITY HOUSING

Based on the recommendations by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention (CDC), the University recommends all incoming students receive a Meningococcal Conjugate Vaccine (MCV) or Meningococcal Polysaccharide Vaccine (MPSV) after the age of 16 regardless of prior vaccination history. **All students residing in University Housing are REQUIRED to obtain this vaccine.**

Since college students are at increased risk for meningococcal disease, which is a serious disease and can be fatal, we want to assure that you have received sufficient information and have had the opportunity to ask questions prior to making the decision to decline the vaccine. We assume you have had a discussion with your health care provider at the time of your physical examination and completion of the health form regarding the seriousness of this disease and benefits of the vaccination.

Please review the Meningococcal Vaccine Information Statement developed by the CDC found on the USciences Student Health Services webpage (http://www.usciences.edu/shac/health/forms.shtml). Feel free to discuss the benefits of the Meningococcal Vaccine further with your health care provider, or call Student Health Services to speak with a health care provider.

If, after reading this information and having the opportunity to ask questions of either your health care provider or the providers at USciences Student Health, you decline the meningococcal vaccine please sign the statement below. If you are under the age of 18, a parent or legal guardian must sign in your place.

Declination of Meningococcal Vaccine

I have read the provided information in the Meningococcal Vaccine Information Statement. I have had the opportunity to ask questions of my primary care provider or the providers at USciences Student Health. I understand the risks of meningococcal disease and the benefits of immunization and hereby attest that I am declining immunization at this time. I understand that I am not eligible to reside in University Housing without having received the meningococcal vaccine.

_____ _____

Signature Student Name (printed)

_____ _____

Signature of parent (if under 18) Parent's Name (if under 18; printed)

_____

Date

THIS WAIVER IS NOT APPLICABLE TO STUDENTS RESIDING IN UNIVERSITY HOUSING

Last Name	First Name	Student ID	Date of Birth

PART III – MEDICAL RECORDS RELEASE

TO BE COMPLETED BY STUDENTS ENTERING THE PHARMD, DPT, MOT, DOT OR, PA PROGRAM

Please read and complete this form if you have been admitted to one of the following Health Professional Programs at the University of the Sciences (USciences): Pharmacy, Physical Therapy, Occupational Therapy, or Physician Assistant.

Health Professional Program (check one):

☐ Pharmacy ☐ Physical Therapy ☐ Occupational Therapy ☐ Physician Assistant

***By signing below**, I authorize the staff of USciences Student Health to provide a copy of the following medical records to my health professional program at the University, clinical training director, and experiential site coordinator within the applicable academic department*:

- Immunization Record
- Hepatitis B and MMR Titer Results
- Personal Health History
- Health Care Provider Evaluation & Physical Exam

Please Note: The information to be released will be limited to these specific items as provided by me to Student Health. No further medical information regarding my medical history and/or my treatment history at Student Health will be released to my academic program as a result of this release. Students will be notified in a timely manner by a Student Health representative if the above noted health records are not received or are incomplete. Students will be placed on a Health Hold if the completed health records are not received.

_____ _____

Signature Student Name (printed)

_____

Date

Last Name	First Name	Student ID	Date of Birth

PART IV - HEALTH CARE PROVIDER EVALUATION & PHYSICAL EXAM

TO BE COMPLETED BY A HEALTH CARE PROVIDER

Note to Health Care Providers Regarding Documentation Requirements Herein: The student who is requesting completion of these medical clearance forms has been admitted to a health sciences university that primarily educates future Health Professionals. As such, the requirements regarding health evaluation, immunization, blood titers, and related documentation are a reflection of the rigorous standards imposed on students as a condition of matriculation in experiential training at various medical centers, hospitals and other clinical sites. These requirements are reflective of national standards as published by the Centers for Disease Control and other public health-specific governing bodies, as disseminated at the time this document went to press, and are therefore subject to change based on subsequent alterations in accepted practice in clinical medicine, epidemiology and public health. *We appreciate your full cooperation in completing this packet as it will ensure the student is not unfairly delayed in progressing through their health professional training program due to failure to comply as requested.*

Date of Physical Exam: _____ (within 1 year of matriculation)

FULLY DESCRIBE ANY ABNORMAL FINDINGS IN THE FOLLOWING SYSTEMS			
	NORMAL	**ABNORMAL**	**Describe**
Head			
Eyes & Funduscopic Exam			Snellen : R = / L = /
Ears			
Nose			
Throat			
Neck			
Lymph Nodes			
Heart			
Lungs			
Breasts			
Abdomen			
External Genitalia			
Hernia (male)			
Musculoskeletal			
Peripheral Vascular			
Neurologic & Cranial Nerves			
Psychiatric /Mental Status			
Skin			

Screening Tests:

Height _____ Weight _____ Body Mass Index _____

Blood Pressure _____ Pulse (resting) _____

Last Name	First Name	Student ID	Date of Birth

Tuberculosis (TB) Screening:

1. **Does the student have signs or symptoms of active tuberculosis disease?** Yes ____ No ____
   ***If NO**, proceed to 2. **If YES**, proceed with additional evaluation as in 3 and 4.*

2. **Is the student a member of a high-risk group?** Yes _____ No _____
   ***If NO**, Stop. **If YES**, place tuberculin skin test.*

For those having had prior BCG vaccination, a QuantiFERON®-TB Gold In-Tube test (QFT-GIT) or T-SPOT®.TB test (T-Spot) is the preferred method of TB infection testing.

3. **Tuberculin Skin Test (TST):** Some academic programs may require a two-step test.

   Step One: Date Given: ____/____/_____ Date Read: ____/____/_____
   MO DAY YR MO DAY YR

   Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")
   Interpretation: Negative _____ Positive _____ (based on mm of induration as well as risk factor)

   Step Two: Date Given: ____/____/_____ Date Read: ____/____/_____
   MO DAY YR MO DAY YR

   Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")
   Interpretation: Negative _____ Positive _____ (based on mm of induration as well as risk factor)

4. **QTF-GIT or T-Spot Test**: For those having had prior BCG vaccination, QTF-GIT or T-Spot test is the preferred method of TB infection testing.

   Result: Negative_____ Positive _____ **COPY OF REPORT REQUIRED**

5. **Chest X-Ray**: Required if TST, QTF-GIT or T-Spot is positive.

   Date: ____/____/_____

   Result: Normal _____ Abnormal _____ **COPY OF REPORT REQUIRED**

Last Name	First Name	Student ID	Date of Birth

Summary, Remarks and Recommendations:

Is there loss or seriously impaired function of any organ? No ___ Yes ___ Explain: _____

_____

_____

_____

Is this student medically cleared to fully participate in collegiate or athletic activities? If not, please explain and note limitations. No ___ Yes ___ Explain: _____

_____

_____

_____

Is the patient now under treatment for any medical or emotional condition(s)? No ___ Yes ___ Explain: _____

_____

_____

_____

If you answered yes to the previous question, do you have any specific recommendations regarding the care of this student? No ___ Yes ___ Explain: _____

_____

_____

_____

Does this student have any communicable disease(s), Tuberculosis or other? No ___ Yes ___ Explain:

_____

_____

_____

_____

Remarks or additional information: _____

_____

_____

_____

_____

_____

HEALTH CARE PROVIDER INFORMATION

Name: _____ Signature: _____

Address: _____ Phone Number: _____

NPI Number: _____ Date: _____

STAMP OF HEALTH CARE PROVIDER'S OFFICE LOCATION:

Last Name	First Name	Student ID	Date of Birth

PART V - IMMUNIZATION RECORD

TO BE COMPLETED BY A HEALTH CARE PROVIDER – ALL INFORMATION MUST BE IN ENGLISH

WE DO NOT ACCEPT COPIES OF RECORDS FROM OTHER FACILITIES AS A SUBSTITUTE FOR COMPLETION OF THIS FORM.

1. HEPATITIS B:

- Three doses of vaccine **REQUIRED**; **AND**
- Positive Hepatitis B Surface Antibody Titer (IgG) **Required** *if series completed* (see page 9)

HEPATITIS B SERIES		
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR

HEPATITIS B REPEAT SERIES		
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR

2. POLIO:

- Primary series **REQUIRED**. Three primary series are acceptable.

POLIO: ☐ IPV ☐ OPV				
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR

3. TETANUS-DIPHTHERIA-PERTUSSIS:

- Primary series of DTap, DTP, DT or Td **REQUIRED**; *Last Td required to be within the last 10 years*
  AND
- One dose of Tdap (tetanus toxoid, reduced diphtheria toxoid and acellular pertussis) vaccine **REQUIRED after May 2005**

TETANUS-DIPHTHERIA-PERTUSSIS				
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR	MO/DAY/YR*

**Last Td vaccine required to be in the past 10 years*

TDAP
MO/DAY/YR:

4. VARICELLA (CHICKEN POX):
History of Disease is Not Sufficient

- If you have had a documented case of Chicken Pox disease, ***one of the following is REQUIRED***:
  - Positive Varicella Antibody Titer (IgG); **OR**
  - Two doses of Varicella vaccine
- If you have not had Chicken Pox disease or have a negative antibody titer two Varicella vaccines are **REQUIRED**.

VARICELLA	
MO/DAY/YR	MO/DAY/YR

VARICELLA ANTIBODY TITER (IgG)	
MO/DAY/YR	UPLOAD OFFICAL LAB RESULTS TO STUDENT HEALTH PORTAL

5. MEASLES, MUMPS, RUBELLA (MMR):

- Two doses of vaccine **REQUIRED**; **AND**
- Positive MMR Antibody Titer (IgG) **REQUIRED** (see page 9)

MEASLES, MUMPS, RUBELLA (MMR)		
MO/DAY/YR	MO/DAY/YR	BOOSTER MO/DAY/YR

6. MENINGOCOCCAL:

- **ALL** Students residing in University housing are **REQUIRED** to obtain the Meningococcal Conjugate Vaccine (MCV) or Meningococcal Polysaccharide Vaccine (MPSV) after their 16th birthday, regardless of prior vaccination history. Students living off-campus are recommended to receive the vaccine, but may sign the Meningococcal Waiver (page 2).
- Additional vaccination against meningitis serogroup B remains optional. Discuss vaccination criteria with your Health Care Provider.

MENINGOCOCCAL *REQUIRED*	
☐ MCV ☐ MPSV	☐ MCV ☐ MPSV
MO/DAY/YR	MO/DAY/YR*

If first vaccine was given before age 16, a second vaccine after the 16th birthday is **REQUIRED.*

MENINGOCOCCAL SEROGROUP B *OPTIONAL/RECOMMENDED*		
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR

7. HUMAN PAPILLOMAVIRUS

- Recommended

HUMAN PAPILLOMAVIRUS ☐ HPV4 ☐ HPV9		
MO/DAY/YR	MO/DAY/YR	MO/DAY/YR

Health Care Provider Signature _____ **Date** _____

Last Name	First Name	Student ID	Date of Birth

PART VI - SURFACE ANTIBODY TITERS

TO BE COMPLETED BY A HEALTH CARE PROVIDER

HEPATITIS B, MEASLES, MUMPS, AND RUBELLA SURFACE ANTIBODY TITERS (IGG) ARE REQUIRED OF ALL UNDERGRADUATE AND POST-BACCALAUREATE STUDENTS AND GRADUATE PHYSICIAN ASSISTANT STUDENTS.
SURFACE ANTIBODY TITERS ARE NOT REQUIRED OF GRADUATE AND DOCTORAL STUDENTS IN NON-CLINICAL PROGRAMS.

Note to Health Care Providers Regarding Documentation Requirements Herein

The student who is requesting documentation of immunization and confirmation of immunity via surface antibody blood titers has been admitted to a health sciences university that primarily educates future Health Professionals. As such, **the requirements regarding full immunization and surface antibody blood titers to confirm immunity are a reflection of the rigorous standards imposed on students as a condition of matriculation in experiential training at various medical centers, hospitals and other clinical sites.** These requirements are reflective of national standards as published by the Centers for Disease Control and Prevention (CDC) and other public health-specific governing bodies, as disseminated at the time this document went to press, and are therefore subject to change based on subsequent alterations in accepted practice in clinical medicine, epidemiology and public health. We appreciate your full cooperation in completing this packet as it will ensure the student is not unfairly delayed in progressing through their health professional training program due to failure to comply as requested.

Hepatitis B Surface Antibody Titer (IgG)

Titer Test Date: ____/____/_____ (MO DAY YR) **Titer Test Results: ** PROVIDE STUDENT WITH OFFICIAL LAB RESULTS ****

In the event that the Hepatitis B titer is negative or shows "equivocal" immunity, the student is **REQUIRED** to repeat a Full Second Hepatitis B series, and obtain a repeat titer 4 to 6 weeks after the last vaccine, as per CDC recommendations.

If the student has a negative Hepatitis B titer and needs to complete a second series, they are **REQUIRED** to upload documentation to the Student Health Portal after each vaccine is administered, and titer results 4-6 weeks after completion of the series.

MMR Surface Antibody Titer (IgG)

Titer Test Date: ____/____/_____ (MO DAY YR) **Titer Test Results: ** PROVIDE STUDENT WITH OFFICIAL LAB RESULTS ****

In the event that the MMR titer(s) is/are negative or show(s) "equivocal" immunity, the student is **REQUIRED** to receive a booster vaccine, and obtain a repeat titer 4-6 weeks later, as per CDC recommendations.

_____ **Health Care Provider Signature**

_____ **Date**