STUDENT HEALTH & WELLNESS REPORTING FORM

Susquehanna University Health Center
514 University Avenue, Selinsgrove, PA 17870-1001
Phone (570) 372-4385 / Fax (570) 372-2729

PART I (REQUIRED)

Name:_____ /____/____
Last First Middle Date of Birth (M / D / Y)

Birth Sex: ☐ Female ☐ Male AND Gender Identity: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Single ☐ Other:_____

Dates Admitted: FROM:____/____/____ UNTIL: :____/____/____ Previously enrolled at SU: ☐ No ☐ Yes - Year(s)_____

Admitted as: ☐ ELL Student ☐ International Full-Time Student for ☐ 1 Year ☐ 4 Years ☐ Other:_____

Citizenship:_____ Country of origin if other than United States:_____

School Address:_____
No. & Street City/Town State Zip

Home Address:_____

Cellular Phone or Local Phone:_____ Email Address:_____

PART II (REQUIRED)

All doses of measles, mumps, rubella (MMR) vaccines must be given after the 1st (first) birthday and after 1967. History of disease not accepted.

MMR	Dose 1	Dose 2
	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)

Serological confirmation of immunity accepted. Attach copoy of lab results. (Must be in English.)

OR

MEASLES	Dose 1	Dose 2
(Rubeola):	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)
MUMPS:	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)
RUBELLA:	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)

PART III (REQUIRED) - TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

All incoming students are required to complete this questionnaire:

Have you ever had a POSITIVE test for TB?	Have you ever been exposed to anyone with active TB?	Have you ever had TB?	Have you received the BCG* vaccine?	Have you ever taken INH/Rifampin** medication?
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

*BCG - not given in US
**INH (Isoniazid) or Rifampin - a medication for TB/Latent TB

In the past year have you had any of the following symptoms for a period of time greater than six months?

Persistent Cough	Persistent Fever	Loss of Appetite	Night Sweats	Chest Pain
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Coughing Up Blood	ShorTness of Breath	Unexplained Weight Loss	Weakness or Fatigue	If "YES", to any explain:
Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	

PART IV (REQUIRED)

	Chicken Pox/Varivaxq	Hepatitis B	Meningococcal Vaccine Menactra ☐ OR Menveo ☐ *Given after age 16 or within past 3 years	TD ☐ OR Tdap ☐ (Within 10 years)
Dose 1	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)		
Dose 2	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)		
	History of disease accepted. Date:_____	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)	____/____/____ (M D YYYY)

Interferon-based Assay must have been performed within the last year.		
Interferon-based Assay TB Blood Test (Quantiferon Gold Test or T-Spot	Date	Result: Attach copy of Lab Report
Chest X-Ray Required if Quantiferon Gold Test of T-Spot is POSITIVE		
Chest X-Ray (needed ONLY if TB Blood Test is POSITIVE)	Date	Result: Attach copy of Radiology Report (in English)

PART V (REQUIRED) – TO BE COMPLETED BY HEALTH CARE PROVIDER

TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the provider's report in English. Please comment on all positive answers. This student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health and mental health care.

LAST NAME (Print):_____ FIRST NAME:_____ DOB:____/____/____

Height:_____ Weight:_____ BP:_____ Temp:_____ Pulse:_____ Respiratory Rate:_____

Visual Acuity: R_____/_____ L_____/_____ Corrected: ☐ Yes ☐ No

Current Medications and Dosage:_____

_____

_____

Physical MUST be completed within one year prior to your arrival on campus. Returned these forms to the Health Center as soon as possible but MUST be received prior to your arrival on campus. Failure to return this record, will result in a hold being placed on your registration, athletic participation and/or your room key will be held upon arrival to campus.

Please assess the following systems. Please describe fully.

System	Normal	Abnormal	Comments
Cardiovascular			
Eyes			
Gastrointestinal			
Genitourinary			
Head, Ears, Nose or Throat			
Hernia			
Metabolic / Endocrine			
Musculoskeletal			
Neuropsychiatric			
Orthopedic Screening			
Respiratory			
Skin			

☐ **CLEARED** for full activity _____ (list sport)

☐ **CLEARED WITH RECOMMENDATION(S)** for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ **COLLISION** ☐ **CONTACT** ☐ **NON-CONTACT** ☐ **STRENUOUS** ☐ **MODERATELY STRENUOUS** ☐ **NON-STRENUOUS**

Is the patient currently under treatment for any medical or psychological condition? ☐ No ☐ Yes - If yes, please explain:_____

_____

Do you have any recommendations regarding the care of this student, not previously addressed? ☐ No ☐ Yes - If yes, please explain:_____

_____

How long have you known this student?_____

If you have any additional recommendations, please feel free to include a note or letter with this health record.

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MUST BE SIGNED BY HEALTH CARE PROVIDER:

Health Care Provider's Name Printed:_____

Health Care Provider's Signature:_____ **Date:**_____

Practice Name & Address:_____

Phone:_____ **Fax:**_____