STUDENT NAME: _____ STUDENT ID: _____

Susquehanna UNIVERSITY

STUDENT HEALTH & WELLNESS REPORTING FORM

— DUE DATE & SUBMISSION —

Completed forms are due NO LATER THAN JUNE 30 for fall enrollment or NO LATER THAN DECEMBER 30 for spring enrollment.

1. Complete pages 1–5 of this form using Adobe Reader and save it as a new file to your computer (as a PDF).
2. Print pages 6–8 and ask your medical provider to complete the health assessment and return it to you.
3. Scan the completed health assessment and add the remaining pages to the PDF you saved on your computer.
4. Upload the PDF (all 8 pages) into the River Hawk Portal and it will be marked as received on the checklist after the information is reviewed.

— TO THE STUDENT —

Information you provide will not be used to influence your situation at the university; it will be used solely as an aid to provide health care while you are a student. Sharing of medical information will be governed by HIPAA regulations. To assist in your care, information on the Student Health and Wellness Reporting Form may be shared with the SU Risk Management team and the SU Counseling & Psychological Services team, if applicable. Health information may be shared with the SU athletic department (provided the Athletic Consent section is signed).

STUDENT INFORMATION

LEGAL LAST NAME | LEGAL FIRST NAME | LEGAL MIDDLE NAME

Students who would like to submit an official request to use a chosen name instead of a name with which they no longer identify can contact the Office of the Registrar. After the request is processed, the registrar's office notifies other university offices and departments so they can update their records, as necessary.

DATE OF BIRTH (MM/DD/YYYY) | BIRTH SEX *(select one):* ☐ Male ☐ Female | GENDER IDENTITY | LAST 4 OF SOCIAL SECURITY #

NOTICE OF PRIVACY PRACTICES AND CONSENT

Act 10 of the General Assembly of Commonwealth of Pennsylvania was approved on February 13, 1970, stating: Any minor who is 18 years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental, or health services for himself or herself, and the consent of no other shall be necessary.

My signature below indicates that:

- I consent to medical and nursing treatment by the Susquehanna University Student Health Center.
- I am aware of the Notice of Privacy Practices available upon request at the SU Student Health Center.
- If I require services, prescriptions or referrals beyond the primary care services available at the SU Student Health Center, I shall assume the financial responsibility or negotiate satisfactory arrangements with the caregiver.
- I understand that my contacts with the SU Student Health Center are held in confidence, but that confidentiality may be broken if my life or that of another person is in danger.
- I give consent to the SU Student Health Center team to communicate confidentially with the SU Risk Management team and subcommittee members as may be necessary for COVID-19 related care and management while I am a student at SU.
- The information on this form is correct and complete to the best of my knowledge.

SIGNATURE OF STUDENT | PRINTED NAME | DATE (MM/DD/YYYY)

STUDENT NAME: _____ STUDENT ID: _____

PERSONAL MEDICAL HISTORY

ALLERGY	YES	NO	SPECIFY ALLERGY	EPI PEN	YES	NO
Drug(s)						
Food(s)						
Insect Sting(s)/Bite(s)						
Other						

Please check any problem(s) that you currently have or have had in the past. If yes for any, indicate onset date and provide explanation in area below.

	YES	NO	ONSET DATE
Abdominal Issues			
Cancer Type: _____			
Family History			
Cardiac Conditions			
Celiac Disease			
COVID-19			
*Complications:*_____			
Cysts or Lumps			
Dental Problems			
Dermatology (Skin Disorder)			
Diabetes			
Ear, Nose, Throat Problems			
Hearing Loss			
Eye Problems			
Gastrointestinal Problems			
Genitourinary Problems/History			
Frequent Urinary Tract Infection			
Kidney Disease			
Kidney Stones			
Prostate Issues			
Testicular Masses/Problems			
HIV/AIDS			
Hypoglycemia			
Infectious Mononucleosis			
Liver Disease/Problems			
Neurological Issues/Disorders			
Head Injury			
Concussion *(type)*:_____			
Epilepsy/Seizures			
Headaches/Migraines			
Neck Injury			
Paralysis			
Pinched Nerve			

	YES	NO	ONSET DATE
Orthopedic Problem *(Note right or left)*			
Ankle: _____			
Arm/Elbow/Wrist/Hand/Fingers: _____			
Back/Ribs: _____			
Foot: _____			
Hip/Groin: _____			
Knee: _____			
Lower Leg: _____			
Shoulder: _____			
Thigh: _____			
Stress Fracture: _____			
Respiratory Problems			
Asthma/Shortness of Breath			
Rheumatologic Diseases			
Sexually Transmitted Disease			
Sickle Cell Anemia/Trait			
Smoke – Cigarettes			
Vape			
Thyroid Problems			
Weight – Recent gain or loss			
Other health problems, including hospitalizations or surgical operations: _____ _____			
Other medical history important to your safety, or to the safety of others, including any loss of or impaired organs: _____ _____			
FEMALES ONLY			
Gynecological, menstrual or obstetrics Issues: _____			
Pregnant			

Please explain all "Yes" responses: _____

STUDENT NAME: _____ STUDENT ID: _____

CURRENT MEDICATIONS

MEDICATION	DOSE	REASON

PERSONAL MENTAL HEALTH / SOCIAL HISTORY

Please note that mental health, like all of your health information, is confidential. The Student Health Center and Counseling & Psychological Services (CAPS) are separate departments. In the future, a consent signed by the student will be obtained before sharing any additional health information. If you wish to discuss mental health issues with a counselor or coordinate an appointment, please call CAPS at 570-372-4751.

Please check any problem(s) that you currently have or have had in the past. If yes for any, indicate onset date and provide explanation in area below.

	YES	NO	YEAR(S)
Depression			
Anxiety			
Bipolar Disorder			
Eating Disorder			
Alcohol/Drug Abuse or Dependence			
Asperger Syndrome/Autism Spectrum			
ADD/ADHD			
Other mental health concerns: _____			

	YES	NO	YEAR(S)
Attended Counseling for Mental Health Concerns			
Taking a Prescribed Medication for Mental Health Concerns			
Been Hospitalized for Eating Disorder or Mental Health Concerns			
Received Treatment for Alcohol or Drug Abuse			
History of Suicidal Ideation/Attempts			

Please explain all "Yes" responses: _____

_____

_____

STUDENT NAME: _____ STUDENT ID: _____

FOR DIVISION III STUDENT-ATHLETES ONLY (excludes club and intramural sports)

By entering my initials below, I understand that I am agreeing to the terms and doing so is the equivalent of my signature.

1. PERMISSION FOR MEDICAL RECORDS RELEASE

_____
STUDENT-ATHLETE INITIALS

I hereby authorize Susquehanna University's sport medicine staff and its insurance agent, to inspect or secure copies of the Susquehanna University Student Health Center's health record. I also consent for the release of medical records of past and future confinements and/or disabilities that may affect my ability to participate in intercollegiate athletic competition. A photocopy of this authorization shall be deemed as effective and valid as the original."

2. ACKNOWLEDGMENT OF RISK AND INFORMED CONSENT

_____
STUDENT-ATHLETE INITIALS

I realize that participation in any sport can be a dangerous activity involving **many risks of injury**. I understand there are risks including and not limited to death or paralysis, brain damage, cardiac arrest, serious injury to internal organs and to bones, joints, ligaments, muscles, tendons and other serious injury or impairment to other aspects of my general health and well-being. I understand that the dangers and risks of participating in sports also include the potentially high cost of medical care and impairment of my future ability to earn a living, to engage in other business, social and recreational activities and generally to enjoy life. Recognizing these risks, I choose to participate in the sport(s) of my choice at Susquehanna University.

3. STUDENT-ATHLETE CONCUSSION STATEMENT

_____
STUDENT-ATHLETE INITIALS

I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician. I have read and understand the NCAA Concussion Fact Sheet. This sheet is located at: **https://suriverhawks.com/sports/2018/8/8/information-sports-medicine-2017-18-Concussion-Fact-sheet-student-athletes-pdf.aspx**

After reading the NCAA Concussion Fact Sheet, I am aware of the following information:

- *A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.*
- *A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep and classroom performance.*
- *You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.*
- *If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.*
- *I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.*
- *Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.*
- *In rare cases, repeat concussions can cause permanent brain damage and even death.*

(continued on next page)

STUDENT NAME: _____ STUDENT ID: _____

FOR DIVISION III STUDENT-ATHLETES ONLY (excludes club and intramural sports)

By entering my initials below, I understand that I am agreeing to the terms and doing so is the equivalent of my signature.

4. SICKLE CELL TRAIT TESTING

_____
STUDENT-ATHLETE INITIALS

I understand and acknowledge that the NCAA and Susquehanna University require all student-athletes to have knowledge of their sickle cell trait status. Susquehanna University and the NCAA require that all student-athletes who are unable to confirm their sickle cell trait status undergo testing prior to participation in any intercollegiate activity.

- *Sickle cell trait is an inherited condition of the oxygen carrying protein, hemoglobin, in the red blood cells.*
- *Sickle cell trait is a common condition affecting more than 3 million Americans.*
- *Although sickle cell trait is most predominant in African Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean and South/Central American ancestry, persons of all races may test positive for sickle cell trait.*
- *Sickle cell trait has been associated with a condition known as exertional rhabdomyolysis, renal failure and death. Complicating factors include extreme exertion, increased heat, altitude and dehydration.*
- *Sickle cell trait is usually benign but during intense sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells which can accumulate in the bloodstream and "logjam" blood vessels, leading to a collapse from the rapid breakdown of muscle starved of blood.*

After reviewing the above information I have elected to *(choose appropriate box)*:

☐ I know my sickle cell trait status and can provide documentation of the results. *(Attach sickle cell status documentation.*)*

☐ I will get tested and provide documented proof of my sickle cell trait status to the sports medicine staff. Failure to submit sickle cell trait results will result in your exclusion from athletic activities until results are received. Attach documentation to your Sports Ware Account. Instructions will be sent to you in the preseason participation letter you will receive from your coach.

SIGNATURE OF STUDENT | PRINTED NAME | DATE (MM/DD/YYYY)

**To access your sickle cell trait status documentation, you must contact your birth hospital and request the newborn sickle cell screen result. Please note that this can take up to six weeks to process. Failure to submit sickle cell trait results will result in your exclusion from athletic activities until results are received. Results can be forwarded to the athletic training staff. You can do this by attaching documentation to your Sports Ware Account. Instructions will be sent to you in the preseason participation letter you will receive from your coach.*

STUDENT NAME: _____ STUDENT ID: _____

HEALTH ASSESSMENT — TO BE COMPLETED BY MEDICAL PROVIDER

This student has been accepted as a student of Susquehanna University, and the information supplied will not affect his/her acceptance status. The information will be used for providing physical and mental health care while the student is a Susquehanna University student.

— MEDICAL PROVIDERS —

Please complete this assessment and comment on all answers marked "abnormal." All information, including immunization dates, must be input into this Susquehanna University form and must be in English. Print outs from provider's office will not be accepted.

A physical exam MUST be completed by you on or after June 30 of previous year and signed by you..

PATIENT: LEGAL LAST NAME | LEGAL FIRST NAME | LEGAL MIDDLE NAME | DATE OF BIRTH (MM/DD/YYYY)

HEIGHT (IN) | WEIGHT | BP | TEMP | PULSE | RESPIRATORY RATE

VISUAL ACUITY: R _____/_____ L _____/_____ CORRECTED? ☐ YES ☐ NO

CURRENT MEDICATIONS & DOSAGES: _____

Please assess the following and describe fully.

SYSTEM	NORMAL	ABNORMAL	COMMENT(S) OR ABNORMAL CONDITION(S)
Cardiovascular			
Eyes			
Gastrointestinal			
Genitourinary			
Head/ Ears/Nose/Throat			
Hernia			
Metabolic/Endocrine			
Musculoskeletal			
Neurological			
Orthopedic Screening			
Psychiatric			
Respiratory			
Skin			

☐ CLEARED for full activity: _____ ☐ CLEARED W/RECOMMENDATIONS: _____

☐ NOT CLEARED for the following types of sports: ☐ Collision ☐ Contact ☐ Non-Contact ☐ Strenuous ☐ Moderately Strenuous ☐ Non-Strenuous

IS STUDENT CURRENTLY UNDER TREATMENT FOR ANY MEDICAL/PSYCHOLOGICAL CONDITION? ☐ NO ☐ YES: _____

ON THE CARE OF THIS STUDENT, ANY ISSUES NOT PREVIOUSLY ADDRESSED? ☐ NO ☐ YES: _____

HOW LONG HAVE YOU KNOWN THE STUDENT? _____ *Any additional recommendations, can be included as a note/letter with this health record.*

SIGNATURE OF MEDICAL PROVIDER | PRINTED NAME & TITLE | DATE (MM/DD/YYYY)

LICENSE # | PHONE | FAX

PRACTICE NAME | ADDRESS, CITY, STATE, ZIP

STUDENT NAME: _____ STUDENT ID: _____

TUBERCULOSIS RISK ASSESSMENT

Individual should be considered at increased risk for TB if any of the following statements are marked "Yes."

	NO	YES
Temporary or permanent residence of ≥1 month in a country with high TB rate — any country other than the United States, Canada, Australia, New Zealand and those in Northern Europe or Western Europe		
Current or planned immunosuppression, including human immunodeficiency virus (HIV) infection, organ transplant recipient, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication		
Close contact with someone who has had infectious TB disease since the last TB test		
Do you currently have ANY of the following symptoms: ☐ Productive Cough *(lasting ≥3 weeks)* ☐ Loss of Appetite ☐ Night Sweats ☐ Persistent Weight Loss without dieting ☐ Swollen Glands *(usually in the neck)* ☐ Hemoptysis *(bloody sputum)* ☐ Persistent Low-Grade Fever		

— MEDICAL PROVIDERS —

If you have indicated "No" to ALL of the above questions, no further action needed. Sign below and proceed to immunization section.
If you have indicated "Yes" to ANY of the above questions, please proceed to the REQUIRED TB testing section below.

IMPORTANT NOTE: If individual has had BCG immunization and has current risk factors, proceed to IGRA. DO NOT do TB skin test.

REQUIRED TB TESTING *(Required for all international students.)*

TUBERCULIN SKIN TEST (TST)

Must be placed within 6 months of college entrance.

Date Given: _____

Date Read: _____

Result *(mm of induration)*: _____

☐ POSITIVE ☐ NEGATIVE

OR

INTERFERON GAMMA RELEASE ASSAY (IGRA)

Date Obtained: _____

Method: ☐ QFT-GIT ☐ T-SPOT

☐ OTHER: _____

☐ POSITIVE ☐ NEGATIVE

☐ INDETERMINATE ☐ BORDERLINE *(T-Spot only)*

☐ **POSITIVE**

CHEST X-RAY (CXR) – REQUIRED IF POSITIVE

Date of CXR: _____

☐ NORMAL ☐ ABNORMAL

Medication: _____

Date Treatment Started: _____

Date Treatment Completed: _____

Provide proof of treatment given for positive TB test:

_____

_____

☐ **NEGATIVE**

DONE.

SIGNATURE OF MEDICAL PROVIDER | PRINTED NAME & TITLE | DATE (MM/DD/YYYY)

LICENSE # | PHONE | FAX

PRACTICE NAME | ADDRESS, CITY, STATE, ZIP

STUDENT NAME: _____ STUDENT ID: _____

IMMUNIZATIONS – REQUIRED

All information, including dates, must be input into this Susquehanna University form and must be in English. Print outs from provider's office will not be accepted. All dates must include month, day and year.

IMMUNIZATION		1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE
COVID-19 *Refer to Susquehanna University requirements and CDC guidelines.*	Two-Dose: type _____	/ /	/ /		
	or				
	Single-Dose: type _____	/ /			
	Booster: type _____				
HEPATITIS B *Three doses of vaccine OR two doses of adult vaccine OR a positive Hepatitis B surface antibody meets the requirement.*	Immunization	/ /	/ /	/ /	
	or				
	HepB Surface Antibody Titers	/ /	Results of Titer: ☐ REACTIVE ☐ NON-REACTIVE		
MMR (Measles/Mumps/Rubella) *Two doses required at least 28 days apart for all students born after 1956.*		/ /	/ /		
MENINGITIS A **(Serogroup A, C, Y, W135) (Menactra, Menveo or Menomune)** *One or two doses for all college students if residing in a residence hall — re-vaccinate every 5 years if increased risk continues. An updated dose is required if more than 5 years ago.*	Quadrivalent Conjugate	/ /	/ /		
	or				
	Quadrivalent Polysaccharide	/ /	/ /		
POLIO (OPV or IPV) *Primary series, doses at least 28 days apart. Three primary series schedules are acceptable.*	OPV	/ /	/ /	/ /	
	or				
	IPV	/ /	/ /	/ /	/ /
TETANUS (TDAP) *Within the past 10 years*	DtaP or DTP	Primary series complete? ☐ YES ☐ NO			
	Tdap	/ /			
VARICELLA (Chicken Pox) *Two doses of vaccine OR history of chicken pox OR positive varicella antibody meet requirement.*	Two Doses	/ /	/ /		
	or				
	History of Disease Date	/ /			
	or				
	Varicella Antibody Titers	Results of Titer: ☐ REACTIVE ☐ NON-REACTIVE			

RECOMMENDED IMMUNIZATIONS (not required)

IMMUNIZATION		1ST DOSE	2ND DOSE	3RD DOSE	4TH DOSE
HEPATITIS A		/ /	/ /		
HPV (Human Papillomavirus Vaccine)		/ /	/ /	/ /	
MENINGITIS (Serogroup B) *For students with functional or anatomic asplenia, HIV, complement deficiency disorders or taking complement inhibitor medications, this is REQUIRED.*	Bexsero	/ /	/ /		
	or				
	Trumenba	/ /	/ /	/ /	

SIGNATURE OF MEDICAL PROVIDER PRINTED NAME & TITLE DATE (MM/DD/YYYY)