**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

# HEALTH PACKET INSTRUCTIONS

***All forms are to be returned to Health Services by JULY 1 for the Fall Semester and DECEMBER 1 for the Spring Semester***

All full-time undergraduate students, all international students, and all residential (graduate and undergraduate) students admitted to Holy Family University are required to submit a completed Health Packet. The student must complete the assigned sections unless the student is under the age of 18 years old, then a parent or guardian is required to complete them. Non-compliance will result in a medical hold for admission into the residence halls and the ability to schedule routine appointments at Holy Family University Health Services. For questions: contact Julia Hummer, CRNP at 267-341-3262 or visit the Health Services website.

**PAGE 2: Demographics, Emergency Contact, Health Insurance, & Family History**

- This form is completed by the *student*.

**PAGE 3: Personal Medical History**

- This form is completed by the *student*.

**PAGE 4: Physical Examination Form**

- This form must be completed and signed by your *Health Care Provider (DO, MD, NP, or PA)*.
- Transfer students who are not on an athletic team can submit a copy of their original college entrance physical.
- Transfer students who are on an athletic team will need to have a physical completed yearly
- Students whose annual physical is in August may submit a copy of their physical from the previous August.

**PAGE 5: Required Meningitis Form**

- This form is completed by the *Health Care Provider and/or student*
- PA Law #955 requires students living in university housing to receive the meningitis vaccine or to sign a waiver of refusal.
- Proof of Meningococcal Meningitis Conjugate Vaccine is required.
- Non-compliance will result in a medical hold for admission into the residence halls.

**PAGE 6: Immunization Form and Tuberculosis Screening**

- This form must be completed and signed by your *Health Care Provider (DO, MD, NP, or PA)* or an official copy of the student's current immunization record should be sent with the Health Packet.
- **The listed vaccines or titer results are mandatory at Holy Family University**.
- Holy Family University Health Services does not supply any mandatory or recommended vaccines. These vaccines are available at many PCP offices, urgent care clinic, CVS MinuteClinics, and federally funded clinics. Please call these locations to verify the vaccines' availability and cost.
- ***Students*** must complete the Tuberculosis (TB) screening section prior to the visit with their Health Care Provider. All international students are required to have a TB test. For U.S. born students, TB testing is only required for those who report risk factors.

**PAGE 7: General Consent, Acknowledgement and Authorization Form**

- This form must be completed by the *student*, if he/she wants to be evaluated by the Health Services' Nurse Practitioner for emergency care and/or elective visits, during his/her enrollment as a student. If the student is under the age of 18, a parent or guardian must complete this consent form.

**Student Athletes:**

The student's Health Care Provider needs to complete the physical on the enclosed form and check the applicable response regarding athletic participation. A letter of explanation from the provider is required for any athlete who is not cleared for unrestricted athletic participation. The letter should include an estimated timeframe for when the student can fully participate in her/his sport. **Please send the signed Physical Exam (pg. 4) to Erin Spaulding, Athletic Trainer, in addition to Health Services.**

***Fax or mail completed forms to Health Services. Fax: 267-341-3691***
***Mail: Health Services, Holy Family University, 9801 Frankford Ave, Philadelphia, PA, 19114***

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

# STUDENTS TO FILL OUT THIS INFORMATION

## STUDENT INFORMATION

Name (PRINT): _____ Date of Birth: _____
(Last) (First) (Middle) (Month/Date/Year)

Student ID Number: _____ Start Term: _____ Age: _____
(Month/Year)

Address: _____

City: _____ State: _____ Zip: _____

Sex: □Male □Female Best Number to contact you: _____ cell/home/dorm Student Athlete: □Yes □No

Select all that apply: □Undergraduate □Graduate □International □Transfer Resident in University Housing: □Yes □No

*Is it okay for Health Services to notify you via your HFU email that we received this packet or to report missing items? □Yes □No

## PARENT OR OTHER TO NOTIFY IN CASE OF EMERGENCY

Name (PRINT): _____ Relationship: _____
(Last) (First)

Address: _____

City: _____ State: _____ Zip: _____

Country: _____ Home Phone Number: _____

Cell Phone Number: _____ Work Phone Number: _____

## HEALTH INSURANCE

Name of Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Group #: _____

*Please attach a copy of both sides of your health insurance, dental & prescription card, if you have it, in case of emergencies. Students should carry a copy of the insurance information.*

| FAMILY HISTORY | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Biological Family Members | Age | Health Status (excellent, fair, poor) | If Deceased: (Cause of Death) | Age of Death | | Do any of your family members have: | Yes | No | Relationship |
| Father | | | | | | Cancer | | | |
| Mother | | | | | | Diabetes | | | |
| Sibling M/F | | | | | | Heart Disease | | | |
| Sibling M/F | | | | | | Kidney Disease | | | |
| Sibling M/F | | | | | | Arrhythmia | | | |
| | | | | | | Sudden Cardiac Death | | | |
| | | | | | | Epilepsy/ Seizures | | | |

*For HFU Office Use: □ Meningitis form □ Vaccines □ Physical □ Completed Date: _____*
*□ Incomplete: _____*

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

Name (PRINT): _____ Date of Birth: _____ Student ID Number: _____

# STUDENTS TO FILL OUT THIS INFORMATION

PERSONAL MEDICAL HISTORY- Please check "YES" or "NO" for every condition. If you check "YES", please explain below.

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ALLERGIES: | | | GASTROINTESTINAL: | | | HEENT: | | |
| -Food Allergies | | | -Chronic Inflammatory Bowel Disease | | | -Hearing Loss | | |
| -Medication Allergies | | | -Acid Reflex/ GERD | | | -Visual Disturbances | | |
| -Seasonal Allergies | | | -Celiac Disease | | | -Corrective Lens | | |
| | | | | | | | | |
| CARDIOVASCULAR: | | | GENITOURINARY: | | | ENDOCRINE: | | |
| -Heart Conditions | | | -Frequent Urinary Tract Infections | | | -Diabetes | | |
| -Heart Murmur | | | -Kidney Stones | | | -Thyroid Disease | | |
| -High blood pressure | | | -Kidney Disease | | | | | |
| -Low blood pressure | | | | | | PSYCHOLOGICAL: | | |
| -Bleeding disorder | | | RESPIRATORY: | | | -Alcohol/ Drug Abuse | | |
| -Sickle Cell Disease/trait | | | -Asthma (sports induced or seasonal) | | | -Anxiety | | |
| -Fainting/ syncope | | | -Chronic Cough | | | -Depression | | |
| -Family History of cardiac death before age 50 | | | -History of Tuberculosis(TB) | | | -Psychiatric Admission | | |
| -Marfan syndrome | | | | | | -Insomnia | | |
| -Blood clots/ PEs | | | DERMATOLOGY: | | | -Learning Disability | | |
| | | | -History of MRSA | | | -ADD/ADHD | | |
| NEUROLOGICAL: | | | -Eczema | | | -Panic Disorder | | |
| -Cerebral Palsy | | | -Psoriasis | | | | | |
| -Migraines | | | -Urticaria/ Hives | | | OTHER: | | |
| -Seizure disorder/Epilepsy | | | | | | -Chicken Pox History | | |
| -Dizziness/ Fainting | | | MUSCULOSKELETAL: | | | -Hepatitis | | |
| -History of head injury | | | -Chronic back/joint pain | | | -HIV | | |
| -Autism Spectrum Disorder | | | -Chronic muscle weakness | | | -Mononucleosis History | | |
| -History of concussion | | | | | | -Cancer | | |

COMMENTS: _____
_____
_____

ILLNESSES NOT LISTED ABOVE: _____
SURGERIES & HOSPITALIZATIONS (Reason/ Year): _____
_____

ALLERGIES: _____

CURRENT MEDICATIONS (Name/ Dosage/ Frequency): _____
_____
_____

**Student/Parent Signature:** _____ **Date:** _____
*Note to Athletes Only: Your signature above authorizes the release of information between Health Services & Athletic Training Staff*

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

Name (PRINT): _____ Date of Birth: _____ Student ID Number: _____

# HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION

## Mandatory Physical Examination for Full-Time Undergraduates

**Name:** _____ **DOB:** _____ **Date of Physical:** _____

**THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER:** *(*THIS FORM MUST BE USED FOR SPORT PHYSICALS)*

**Exam: Height:** _____ **Weight:** _____ **BP:** _____ **P:** _____ **T:** _____ **BMI:** _____ **Vision: L** _____**R**_____

**Statement as to student's physical and mental status, and any restrictions:**

| √ *Check = Normal Circle = N/A* | **Note Variances, Abnormal or Significant Findings** |
|---|---|
| ☐ **General**: Healthy appearing, in no acute distress | |
| ☐ **Skin**: Warm, pink, dry with no rash or lesions | |
| ☐ **Head/Face**: Norm cephalic. Normal Hair Growth | |
| ☐ **Eye**: Sclera white. PERRLA. | |
| ☐ **Nose/Sinuses**: Sinuses nontender to palpation, nares | |
| ☐ **Ears**: No pain when helix pulled. External canal normal. TM with light reflex and landmarks present without erythema, injection, bulging, fluid, retraction, perforation or drainage. No hearing loss. | |
| ☐ **Pharynx**: Good dental hygiene. No tonsilar hypertrophy. No erythema, swelling, injection, exudate or lesions of palate/pharynx. Uvula midline. | |
| ☐ **Neck**: Supple with full ROM. No cervical adenopathy. No thyromegaly. | |
| ☐ **Respiratory**: Respirations easy and nonlabored. Aerates all lobes well. Lungs clear to auscultation and percussion. No pleural rub heard. | |
| ☐ **Cardiovascular**: Regular S1, S2 without murmur, gallop or rub. No peripheral edema. | |
| ☐ **Abdomen**: Soft, nondistended with active bowel sounds x 4. No hepatosplenomegaly. No abdominal guarding, rigidity, tenderness or masses on palpation. No CVA tenderness. | |
| ☐ **Musculoskeletal**: Extremities with full ROM, no varicosities. | |
| ☐ **Neurologic**: Oriented x 3. Cranial nerves II-XII intact. | |
| ☐ **Breast**: Symmetrical, no masses/lumps, no dimpling, no palpable nodes, no nipple discharge, no retraction, no tenderness, BSE discussed. | |
| ☐ **Genitourinary**: External genitalia and hair distribution WNL, inguinal nodes WNL, no urethral lesions or tenderness. | |
| ☐ **Psychiatric:** Specify disorder. | |

List all medication allergies: _____
List all current medications: _____
☐ Yes ☐ No Any pertinent physical findings (e.g. heart murmur, etc.) Specify: _____
☐ Yes ☐ No Any recommendations for limitation of physical activity? Specify: _____
☐ Yes ☐ No Is this individual under care for a chronic condition or serious illness? *If yes, attach letter of recommendations.*
☐ Yes ☐ No Any recommendations for special dietary requirements? Specify: _____

**MANDATORY RESPONSE BELOW FOR SPORTS PHYSICALS:**

_____ Unrestricted athletic participation _____ No participation Explain_____
_____ Conditional athletic participation Explain_____

**Provider's Signature** _____ **DO, MD, NP, PA Date** _____

**Address** _____ **Telephone (** **)** _____

**City/State/Zip** _____ **Fax (** **)** _____

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

Name (PRINT): _____ Date of Birth: _____ Student ID Number: _____

# PROVIDER AND/OR STUDENT TO FILL OUT THIS INFORMATION

## REQUIRED MENINGITIS FORM

Pennsylvania passed Senate Bill 955 which REQUIRES all students wishing to reside in university owned housing to provide either proof of vaccination for meningitis or a signed waiver requesting exemption after having received information on the risks associated with meningococcal disease and the availability and effectiveness of the vaccine. MOVING IN OR RESIDING IN STUDENT HOUSING IS PROHIBITIED UNTIL THIS FORM IS COMPLETED. THERE WILL BE NO EXCEPTIONS.

**What is meningococcal meningitis?** Outbreaks are rare, but this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death. College students are at increased risk, due to living in close-quarters with other students.
**How is it spread?** Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
**What are the symptoms?** Include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, and confusion.
**Who is at risk?** Anyone, but more common in infants, children, and college students (particularly students who live in residence halls). Other undergraduates should also consider vaccination to reduce their risk for the disease.
**Can meningitis be prevented?** Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective in preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause the disease in the United States. At least 70% of all cases of meningococcal disease in college students are vaccine preventable. After vaccination, immunity develops within 10 to 14 days and remains effective for approximately 3 to 5 years. The vaccine is safe, with mild and infrequent side effects, such as fever, redness and pain at the injection site lasting for a couple days. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals. It does not protect against viral meningitis.
**For more information:** Contact your primary care provider (PCP), visit the web sites of the Center for Disease Control and Prevention (CDC): www.cdc.gov/ncidod/dbmd/diseaseinfo, and the American College Health Association: www.acha.org.
The Holy Family University Health Services does not supply any required vaccinations. The meningitis vaccine is available at many PCP offices, urgent care clinic, CVS Minute Clinics, and federally funded clinics. Please call these locations to verify the vaccine's availability and cost.

**PLEASE CHECK ONE BOX (RECEIVED OR DECLINE) BELOW:**

### □ RECEIVED the Meningococcal Meningitis conjugate vaccine (A/C/Y/W-135).

- If initial dose given prior to 16th birthday, two doses are required.
- If initial dose given at 16 years of age or older, one dose is required.

| DOSE #: | VACCINE NAME: | DATE(month/day/year): |
|---|---|---|
| Dose 1 | | |
| Dose 2 | | |

*PLEASE ATTACH IMMUNIZATION RECORD OR PROOF OF VACCINATION.*

### □ DECLINE to receive the Meningitis vaccine(s)-COMPLETION OF WAIVER BELOW IS REQUIRED.

HOLY FAMILY UNIVERSITY MENINGOCOCCAL VACCINATION WAVIER:

I, _____, received and reviewed the information provided by Holy Family University regarding meningococcal disease. I am fully aware of the risks associated with meningococcal disease, and of the availability and effectiveness of the vaccinations against the disease. I knowingly decided NOT to receive a vaccination against meningococcal disease for religious, medical or other reasons. I understand that in declining this vaccine, I continue to be at risk for this disease

**Student Signature: _____ Date: _____**
**Parent Signature: _____ Date: _____**
*Note to Residents: Students under the age of 18 must secure the signature of their parent of guardian if they did not receive a vaccination against meningococcal disease and plan to reside in university owned housing.*

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

Name (PRINT): _____ Date of Birth: _____ Student ID Number: _____

# HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION

## REQUIRED IMMUNIZATION HISTORY

*To satisfy the mandatory vaccine requirements, you must have received the vaccine(s) or provide titer results, which is blood testing that shows immunity. Must be completed and signed by a health care provider or attach a copy of immunization history (must include mandatory immunizations below). If the mandatory vaccines are contraindicated due medical or religious reasons, you must attach and submit the "Vaccine Waiver" signed by your health care provider or clergy. This is in addition to the meningitis waiver.*

| **MANDATORY VACCINES (Please complete or attach copy of immunization)** | **DOSES (month/day/year)** | | | **TITER: DATE & RESULTS (If negative, will need vaccines)** |
|---|---|---|---|---|
| MMR (Measles, Mumps, Rubella) | 1. | 2. | | |
| Tetanus-Diphtheria (Td or Tdap within last 10 years) | 1. | | | |
| Polio (Date Series Completed) | 1. | | | |
| Varicella (Vaccinations or Documented illness date) | 1. | 2. | | |
| Hepatitis B | 1. | 2. | 3. | |

| **RECOMMENDED VACCINES (Please complete or attach copy of immunization)** | **DOSES (month/day/year)** | | | **TITER: DATE & RESULTS (If negative, will need vaccines)** |
|---|---|---|---|---|
| Serogroup B Meningococcal | 1. | 2. | 3. | |
| Meningococcal conjugate (A/C/Y/W-135) | 1. | 2. | | |

**TUBERCULOSIS SCREENING (STUDENT please review and CIRCLE any risk factors in each section that apply)**

**Section 1: Have you had any of these possible symptoms of Tuberculosis?** Unexplained weight loss; fevers over 1 week; Night sweats; Chest pain; Loss of appetite; Persistent cough lasting more than 3 weeks; Coughing up blood.

**Section 2: Do you have any risk factors for tuberculosis?** Close contact with person known or suspect of having tuberculosis; IV Drug user; Immunocompromised; HIV infection; Health care worker; Resident, volunteer or employee in a congregate living setting (homeless shelter, correctional facility, nursing home); A positive Tuberculosis test in the past

**Section 3: Were you born, lived in, or traveled for 30 days or more in any of these areas of high prevalence of Tuberculosis?** □Africa □Asia □Central America □South America □Eastern Europe □Russia

The World Health Organization (WHO), Center for Disease Control (CDC), and the American College Health Association (ACHA) recommend Tuberculosis testing on all individuals at risk of Tuberculosis.

**Did you circle any of the risk factors in any of the 3 sections above or are you an international student?**

□ **YES.** If yes, a Tuberculosis test is required through a PPD skin test, IGRA blood test, or chest radiography. All international students are required to have a Tuberculosis test. (Must be done within the last 12 months).

□ **NO.** If no, you are not required to have a tuberculosis test.

**Student/ Parent Signature:**_____ **Date:**_____

**TUBERCULOSIS TEST (Only REQUIRED if you checked "YES" in the screening above)**

| **DATE APPLIED** | **ARM** | **METHOD** | **ANTIGEN** | **MANUFACTURER** | **SIGNATURE** |
|---|---|---|---|---|---|
| | | | | | |

| **DATE READ** | **RESULTS** | **INDURATION(mm)** | **SIGNATURE** |
|---|---|---|---|
| | | | |

**Chest X-Ray (Attach a copy of the report): Date:** _____ **Results:** _____
**IGRA (Attach a copy of the report): Date:** _____ **Results:** _____

****If positive reaction is reported, the provider must include a letter that the student is free from TB or under adequate TB treatment*

**Provider's Name (Print):**_____ **License Number:** _____
**Provider's Signature:** _____ **Date:** _____
**Address:** _____ **Phone:** _____
Patient's Name (PRINT): _____ Date of Birth: _____ Student ID Number: _____

**Health Services**
**9801 Frankford Ave., Philadelphia, PA 19114**
**Phone: (267)341-3262 | Fax: (267)341-3691**

STUDENTS TO FILL OUT THIS INFORMATION

# General Consent, Acknowledgement and Authorization Form

**Consent to Treatment**

I, _____ (student's name) consent to evaluation and/or treatment of the condition for which I, or my dependent, has come to Holy Family University Health Services, and authorize the licensed Nurse Practitioner employed by Holy Family University to provide such evaluation and/or treatment. I consent to all physical examinations, injections, collection of laboratory specimens, venipuncture, and all other testing deemed necessary during a visit with the Holy Family University Health Services' providers. I understand and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any treatment, evaluation, diagnosis, or test preformed at Holy Family University Health Services. I authorize Holy Family University Health Services to examine, use, dispose, and store all specimens, bodily fluids, and tissues removed from the patient's body. I understand that the services at Holy Family University Health Services will be provided by a licensed Nurse Practitioner. I agree to ask any and all questions before injections given, laboratory specimens are collected, and/or appropriate testing is performed. I acknowledge and agree that this consent will be applicable to any and all visits, emergency care, or episodes of treatment and evaluations by the Holy Family University Health Services' providers.

**Confidentiality**

We are required by law to maintain the privacy and security of your protected health information. All services provided by Holy Family University Health Services are confidential, and are not released to a third party without written permission. Ethical and legal guidelines permit disclosure when a student is in critical condition or there is a threat to self or others. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

I acknowledge that I have had an opportunity to read and review the information contained in the Holy Family University Health Services' Notice of Privacy Practice.

**Acknowledgment of Financial Responsibility**

Services provided by Holy Family University Health Services are free to students, with some exceptions. Any and all laboratory tests and specimens (titers, urine cultures, throat cultures, etc.) sent to an outside lab (LabCorp) will be charged to the student's health insurance. LabCorp is the only laboratory that Holy Family University Health Services uses to process ordered laboratory tests. Any and all prescriptions will be charged to the student's health insurance. Any and all referrals, additional testing, and follow up visits through another providers or organization will be charged to the student's health insurance. If the student does not have health insurance, all acquired cost are billed directly to the student, and are the financial responsibility of the student. It is the student or policy holder's responsibility to verify coverage of any and all LabCorp lab test, prescriptions, and/or referrals prior to the visit. Holy Family University Health Services can change the terms of the cost, payments, and reimbursement for their services at any time.

I understand that I am responsible for paying the cost of any services at the time services are provided, and responsible for making payments in full for any and all services. Holy Family University Health Services is not responsible for obtaining reimbursement on my behalf, or assisting me in obtaining reimbursement from any sources. I understand that I am responsible for any charges that I incur by choosing to utilize the services of Holy Family University Health Services.

By signing below, I confirm my understanding of the above information and my consent to the above disclosures. You must be over the legal age of 18 years old, to sign this form of consent.

Signature:_____ Date:_____

If signed by anyone other than the student, check the box that describes the relationship to the patient:

□ Parent □ Guardian □ Healthcare Agent □ Other