CHESTNUT HILL COLLEGE

Health Services

9601 Germantown Avenue
Philadelphia, PA 19118-2693
(215) 248-7111

CHESTNUT HILL COLLEGE

Please print in blue or black ink.

You are responsible for returning this form in its entirety to Health Services. We suggest making a copy for your records.

PART I: TO BE FILLED OUT BY THE STUDENT

Full legal Name _____ (Last) _____ (First) _____ (Middle) Date _____

Date of Birth _____ Age _____ Sex _____ Social Security Number _____

Home Address _____ (Number and Street) _____ (City) _____ (State) _____ (Zip) _____ (Country)

Class at CHC _____ Telephone # ( ) _____

Marital Status _____ Birthplace _____ Religion _____ (Optional)

Physician _____ Telephone # ( ) _____

Address _____ (Number and Street) _____ (City) _____ (State) _____ (Zip)

Medical Insurance _____ Telephone # ( ) _____ Policy # _____

Address _____ (Number and Street) _____ (City) _____ (State) _____ (Zip) Subscriber _____

Next of Kin or person to be notified in case of emergency

Name _____ Telephone # ( ) _____

Home Address _____ (Number and Street) _____ (City) _____ (State) _____ (Zip) Relationship _____

TO ALL STUDENTS, PARENTS, and PHYSICIANS: Please be candid on this form. This person will be attending **Chestnut Hill College** for the next few years and anything short of full disclosure could be mutually disadvantageous. This is a highly confidential document for sole use by the professional staff at **Chestnut Hill College** Health Services. **NO INFORMATION ON THIS FORM MAY BE RELEASED TO ANYONE WITHOUT THE STUDENT'S PRIOR WRITTEN CONSENT**. If there are any questions, please contact the Director of Health Services at **(215) 248-7111**.

Medical Care Authorization

I, the undersigned, hereby specifically authorize **Chestnut Hill College** Health Services, and/or any authorized member of its staff, to provide care in the **Chestnut Hill College** Health Service office and for emergency treatment, including mental health.

SIGNATURE OF STUDENT – If under 18, signature of both parents/guardians and student is required.

Student _____ Date _____

Parent/Guardian _____ Date _____

NOTE: Without This Signed Authorization, Health Services Cannot Treat This Student

Information you provide will not affect your situation at the college; it will be used only as an aid to providing health care while you are a student. This information is strictly for the use of the Health Services and will not be released to anyone without your knowledge and consent. Complete this section before your physical exam. DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? If you answer "YES" to any of the following please explain in the space provided.

		YES
1	ALLERGIES TO: (please identify)	
1a	Medication	☐
1b	Food	☐
1c	Environment	☐
2	CUTANEOUS (SKIN)	
2a	Acne	☐
2b	Eczema /allergic skin disease	☐
2c	Ophthalmic problems (include glasses/contacts	☐
3	RESPIRATORY	
3a	Asthma	☐
3b	Bronchitis	☐
3c	Hay Fever	☐
4	CARDIOVASCULAR (HEART)	
4a	Heart murmurs (specify if possible)	☐
4b	Heart pounding/skipping	☐
4c	Rheumatic Fever	☐
5	GASTROINTESTINAL	
5a	Hepatitis	☐
5b	Ulcerative colitis/Crohn's Disease	☐
6	GENITOURINARY	
6a	Amenorrhea (no periods)	☐
6b	Cystitis (bladder infection)	☐
6c	Dysmenorrhea (painful periods)	☐
6d	Nephritis or other kidney disease	☐
7a	Back problems	☐
7b	Fractures/Joint disability	☐
7c	Severe sprains, ligament injury	☐
8	METABOLIC/ENDOCRINE/NUTRITION	
8a	Diabetes	☐
8b	Thyroid disorder (specify)	☐
8c	Eating disorder (anorexia, bulimia)	☐

		YES
9	HEMATOLOGIC	
9a	Anemia	☐
9b	Mononucleosis	☐
10	NEUROLOGIC/PSYCHIATRIC	
10a	Dizzy or fainting spells	☐
10b	Frequent or severe headaches	☐
10c	Seizures	☐
10d	Severe depression	☐
10e	Other	☐
11	INFECTIOUS DISEASES	
11a	Tuberculosis	
11b	Mumps	☐
11c	Rubella (German measles)	☐
11e	Measles	☐
12a	Have you ever been hospitalized or had any operations? (explain below)	☐
12b	Do you smoke?	☐
12c	Do you take any medications (include vitamins and birth control pills)? Please list below	☐

FAMILY HISTORY

	Age	State of Health	Occupation	Age/Cause of death
Father				
Mother				
Sisters				
Brothers				
Children				

PLEASE USE THIS SPACE TO ELABORATE BY ITEM NUMBER, THE COURSE AND OUTCOME OF ALL SITUATIONS IDENTIFIED IN THE "YES" COLUMN above OF THE HEALTH FORM. Please include the name of any medication you take.

All of the information on this form is accurate to the best of my knowledge.

Signature: _____ Date: _____

Last Name: _____ First Name: _____

PART 2: MUST BE COMPLETED AND SIGNED BY A HEALTHCARE-PRACTITIONER.

To the practitioner: Please review the student's history and complete the physical exam and immunization record. Please comment on all
positive answers.

Ht. _____ Wt. _____ BP _____ Visual Acuity Uncorrected L20/ R20/ Corrected L20/ R20/

	Normal	Abnormal	Please comment on all abnormal (use space below if needed)
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Muscular/ skeletal			
Metabolic/Endocrine			
Skin			
Psychiatric			
Neurological			

Comments:

Recommendations for physical activities
(Intercollegiate Athletics, Intramurals, Physical Education)

By signing here, I_____ authorize the
Health Office to share a copy of this physical with Intercollegiate Athletics

SIGNATURE OF HEALTHCARE PRACTITIONER:

Health Practitioner _____ Date _____

Address: _____
Street *City* *State* *Zip*

Phone: _____

PART 3: TO BE COMPLETED AND SIGNED BY A HEALTHCARE PRACTITIONER

Chestnut Hill College requires documentation of immunity to measles, rubella and mumps. In accordance with the recommendations of the Pennsylvania State Public Health Department, acceptable proof of immunity for measles means **TWO** doses of live vaccines, the first one administered on or after the first birthday and the second after 15 months of age. There must be an interval of at least 30 days between the first and the second doses. Serological proof of immunity is also acceptable, as is a physician statement of disease. Acceptable proof of rubella means one dose of vaccine given on or after the first birthday or serological evidence. Acceptable proof of mumps means one dose of vaccine given on or after the first birthday, serological evidence or physician statement of disease. Persons born prior to January 1, 1957 are exempt from this requirement.

Please list exact dates (month, day, year) for all immunizations:

Immunization Dates

MMR 1st injection: ___ / ___ / ___
MMR 2nd injection: ___ / ___ / ___

Measles 1st injection: ___ / ___ / ___
Measles 2nd injection: ___ / ___ / ___
Rubella injection: ___ / ___ / ___
Mumps injection: ___ / ___ / ___

Tuberculin Information*

when appropriate for high-risk students according to the CDC guidelines.

PPD Placed Date: ___ / ___ / ___
PPD Read Date: ___ / ___ / ___
PPD Result ___MM X ___MM
Chest x-ray Date: ___ / ___ / ___
Chest x-ray Result: _____

Serologic Evidence Dates

Results

Measles titre: ___ / ___ / ___
Rubella titre ___ / ___ / ___
Mumps titre: ___ / ___ / ___

Other Immunization Dates

Tetanus: ___ / ___ / ___
Polio Completed: ___ / ___ / ___

Disease Dates

Measles: ___ / ___ / ___
Mumps: ___ / ___ / ___

Hepatitis B

The American College Health Organization in conjunction with the Advisory Committee on Immunization Practice recommends that all college students receive the Hepatitis B Vaccine.

HepB 1st injection: ___ / ___ / ___
HepB 2nd injection: ___ / ___ / ___
HepB 3rd injection: ___ / ___ / ___

Other Immunizations (recommended)

HepA 1st injection: ___ / ___ / ___
HepA 2nd injection: ___ / ___ / ___

Varicella 1st injection: ___ / ___ / ___
Varicella 2nd injection: ___ / ___ / ___
Varicella Disease: / /

Meningitis injection: ___ / ___ / ___

A new Pennsylvania law states that the Health Office must have documentation of your vaccination against meningitis on record if you will be living in college housing or a signed waiver declining immunization

Signature of Healthcare Practitioner:

Health Practitioner_____ Date_____

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