Student Health Record

Summer/Fall 2020 Due Date: August 7, 2020

Spring 2021 Due Date: January 8, 2021

HEALTH RECORD SECTIONS TO BE COMPLETED BY THE STUDENT	HEALTH RECORD SECTIONS TO BE COMPLETED BY HEALTH CARE PROVIDER
Personal Health History – Online **Part 1** – Demographics (page 1) **Part 2** – Permission to Release Records *(*page 2) **Immunization Record** – Online	**Part 3** –Evaluation & Physical Exam (pages 3-5) **Part 4** – Immunization Record (page 6) **Part 5** – Surface Antibody Titers (page 7)

- **Submit your Student Health Record to the Student Health Portal at: shac.usciences.edu**

- **If you have questions or concerns, please contact Student Health Services for guidance.**

Phone: 215-596-7133 or 215-596-8980

Email: shac@usciences.edu

Student Health Record

PART 1 – DEMOGRAPHICS

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

Legal Name of Student: ____

Last Name First Name Middle Name

Preferred Name: ____

USciences Student ID Number: ________________________ **Date of Birth:** ___________________

Biological Sex: ______________ **Gender Identity:** ________________ **Pronouns:** ________________

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: ☐ Learning Living Commons (LLC) ☐ Osol ☐ Wilson

Cell Phone Number: ______________________ **Email Address:** _______________________________________

Place of Birth: ____

City State Country

In case of emergency, contact:

Name: __________________________ **Relationship:** ________________ **Telephone Number:** ___________________

Name: __________________________ **Relationship:** ________________ **Telephone Number:** ___________________

Last Name ______ First Name ______ Student ID ______ Date of Birth ______

PART 2 – MEDICAL RECORDS RELEASE

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

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 Services 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 academic department indicated above:*

- Immunization Record
- Hepatitis B and Measles, Mumps and Rubella (MMR) Surface Antibody Titer Results (blood test results)
- Health Care Provider Evaluation & Physical Exam

Please Note: The information to be released will be limited to the specific items listed above. No further medical information regarding your medical history and/or your treatment history at Student Health Services will be released to your academic program as a result of this release.

______________________________ Signature

______________________________ Student Name (printed)

______________________________ Date

PART 3 - HEALTH CARE PROVIDER EVALUATION & PHYSICAL EXAM

TO BE COMPLETED BY A HEALTH CARE PROVIDER
ACCEPTABLE WITHIN ONE YEAR OF STARTING CLASSES

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: ___________________________ (acceptable within 1 year of starting classes)

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			
Hernia (male)			
Musculoskeletal			
Peripheral Vascular			
Neurologic & Cranial Nerves			
Psychiatric /Mental Status			
Skin			

Screening Tests:

Height ______ Weight ______ Body Mass Index ______
Blood Pressure _______ Pulse (resting) _______

Tuberculosis (TB) Screening

- A one-step PPD or a QuantiFERON®-TB Gold In-Tube test (QFT-GIT) is required if student **has had** either:
  - a negative QFT-GIT or a negative two-step Tuberculin Skin Test (PPD) within the last year

    OR
  - an initial negative two-step PPD and an annual negative one-step PPD every year since

- An initial two-step PPD or initial QFT-GIT is required if student **has not had** either of the above.
  - **For those having had prior BCG vaccination**, a QFT-GIT or T-SPOT®.TB test (T-Spot) is the recommended method of TB infection testing (see Centers for Disease Control and Prevention guidelines).

- **If you have had a prior positive PPD or positive QTF-GIT**, you will need to meet with the Director of Student Health to determine the best course of action for TB Screening moving forward. Please call 215-596-7133 or 215-596-8980 to schedule an appointment.

TB testing---only one of the following is necessary. Please see above for guidance on the type of test recommended.

- **Tuberculin Skin Test (TST):** Two-step test is required if patient has not been tested in the past year. One-step test required if patient has been tested in the past year.

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

- **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 _________ <u>**COPY OF REPORT REQUIRED**</u>

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

  Date: ____/____/_____

  Result: Normal _________ Abnormal _________ <u>**COPY OF REPORT REQUIRED**</u>

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:

USciences University of the Sciences | Student Health and Counseling (SHAC)

Last Name	First Name	Student ID	Date of Birth

PART 4 - 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*

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**

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**

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.
- 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**

PART 5 - SURFACE ANTIBODY TITERS

TO BE COMPLETED BY A HEALTH CARE PROVIDER

HEPATITIS B, MEASLES, MUMPS & RUBELLA SURFACE ANTIBODY TITERS ARE REQUIRED OF ALL STUDENTS.

Hepatitis B Surface Antibody Titer (IgG)

Titer Test Date: ____/____/_____ **Titer Test Results: ** PROVIDE STUDENT WITH OFFICIAL LAB RESULTS ****

MO DAY YR

In the event that the Hepatitis B titer is "nonreactive" 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.

Students with a negative surface antibody titer must upload initial titer results and documentation of a booster vaccine by the deadline in order to avoid a late fee.

- If you are completing a second Hepatitis B immunization series, you must upload documentation after each vaccine in order to avoid a Health Hold.

Measles, Mumps, and Rubella (MMR) Surface Antibody Titers (IgG)

Titer Test Date: ____/____/_____ **Titer Test Results: ** PROVIDE STUDENT WITH OFFICIAL LAB RESULTS ****

MO DAY YR

In the event that any part of the MMR titer is "negative" or shows "equivocal" immunity, the student is REQUIRED to receive a booster vaccine, and obtain a repeat titer 4-6 weeks later.

Students with a negative surface antibody titer(s) must upload initial titer results and documentation of a booster vaccine by the deadline in order to avoid a late fee.

________________________________ ________________________________

Health Care Provider Signature **Date**