I, ____________________, give both Global Education and Millersville University Health Services Department permission to receive and freely exchange my Student Health History.

__________________________________
Signature

__________________________
Date
Instructions for Completing Medical Forms

These detailed instructions are for both you and your physician (doctor) and are specifically intended to help international students complete all of the forms as easily as possible. Please read them carefully. The entire completed packet of forms should be emailed to: International.Students@Millersville.edu

Student Health History (Page 1)

To be completed by the student

A. Personal Information: Fill out the entire section. The MU ID# is your Millersville number. If you do not yet know this number, leave blank. Emergency Contact: Complete with person’s name and contact information of whom you would like Millersville to contact in the event of a medical emergency.

B. Family History: Complete this section being as specific as possible

C. Personal History: Complete this section being as specific as possible

D. Tuberculosis Screening
   • Read sections 1-4 and circle any of the risk factors that apply to you.
   • Complete the last box by checking either “No” if none of the above items apply to you, or “Yes” if any of the above items apply to you.
   • If you checked “Yes” a TB test or chest radiography is required. Additional information is found on the Practitioner’s Report (Section A, pg. 2).
   • If you receive a chest radiography, a copy of the report MUST be included with this packet.

E. Student Signature and date: a student signature is needed for this form to be accepted

Practitioner’s Report (Page 2)

To be completed by your doctor according to your current health status. In order to complete this form, your doctor needs to see the Student Health History Form (Page 1).

A. Tuberculosis Screening - If you circled any of the risk factors in Sections 1-4 of the Tuberculosis Screening section on the Student Health History (Section D pg 1.), your doctor needs to give you a Tuberculin Skin Test and record the results OR do a Chest Radiography

B. Mandatory Immunizations/Required Vaccinations:
   i. Measles, Mumps, Rubella (MMR) – Must have 2 doses as indicated on form or MMR titer – date of titer and copy of results must be attached.
      If you must receive your MMR doses at MU, the cost is approximately $85.
   ii. Tetanus-Diphtheria – Must have received within past 10 YEARS.
      If you must receive your updated tetanus at MU, the cost is approximately $45.
   iii. Meningococcal Vaccine
      a. If living in the dormitories, you MUST have this vaccination or sign the waiver in this section.
      b. If you sign the waiver, your doctor must provide a statement, in English, why he/she will not issue you the vaccination.
      c. If living off campus, it is your choice to get the vaccination or not but it is highly recommended.
   iv. Other Immunizations Recommended: These are optional. You do not need to get these vaccinations; however, if you have had them, have your doctor list the details in this section.

C. Physical Examination – (within the past 12 months of admission for all freshman students and within 36 months of admission for all transfer and graduate students). This form must be completed by your doctor.

D. Doctor Information - Your doctor (practitioner) must sign, date, and provide the requested information listed in Section D.

For any questions or concerns please contact Global Education at International.Students@Millersville.edu.
Student Health History

STUDENT: Complete page 1 prior to your appointment with your Practitioner. Be sure to always carry your current health insurance card in the event that it is needed.

MU id#: __________________________ Name: __________________________ Date of birth: __________________________

Male □ Female □ Perm. (Home) Address: __________________________ City: __________________________ State: ________ Zip: ________

Home Phone: __________________________ Cell Phone: __________________________

Emergency Contact- Name: __________________________ Phone: __________________________ Relation: __________________________

Family History -

<table>
<thead>
<tr>
<th>Biological/Family Member</th>
<th>Age</th>
<th>State of Health</th>
<th>If Deceased: Cause of death</th>
<th>Age at death</th>
<th>Do you or any of your biological family members have:</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling M/F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Epilepsy, Seizures</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling M/F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hypertension</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sibling M/F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Sudden Cardiac Death before age 50
- Kidney Disease
- Mental Health History
- Thyroid Disease

Personal History – Have you ever had any of the below? If yes, please comment on all positive answers in the space provided below.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Eyes</th>
<th>Yes</th>
<th>No</th>
<th>Neurological/Psychological:</th>
<th>Yes</th>
<th>No</th>
<th>Skin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>-Visual Disturbances</td>
<td>-Dizziness/Fainting</td>
<td>-Hemiplegia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular:</td>
<td>Corrective Lenses</td>
<td>Frequent Headaches</td>
<td>Skin Lesions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Heart Murmur
- High Blood Pressure
- Low Blood Pressure
- Bleeding Disorder
- Sickle Cell Disease/ Trait

Gynecological: -History of concussion

Ears, Nose, Throat:
- Severe Cramps
- Inguinal Hernia
- Prolapsed Anal Prolapse
- Tonsillectomy
- Thyroid Problems
- Chronic Muscle Weakness
- Chronic Back/Joint Pain

Endocrine:
- Musculoskeletal:
- Diabetes
- Chronic Muscle Pain

- Asthma
- Chronic Cough
- Current or Past Military Service?

Comments:

Tuberculosis Screening (please review and *circle* any risk factor in each section that apply)

Section 1: Possible Symptoms of Tuberculosis? Unexplained: weight loss; elevation of temperature for more than one week; night sweats; persistent cough for more than 3 weeks; cough productive of bloody sputum...

Section 2: Risk Factors for Tuberculosis Infection? Close contact with known case of infectious tuberculosis; use of illegal injected drugs; HIV (human immunodeficiency virus) infection; Health care worker; resident or employee in a congregate living setting (nursing home, homeless shelter, correctional facility); a positive skin tuberculosis test in the past.

Section 3: Risk Factors for Tuberculosis Disease? Diabetes mellitus; lymphoma, leukemia, or cancer of the head, neck or lung; gastrectomy or jejunulo-ileal bypass (gastric bypass surgery); greater than 10% below ideal body weight; silicosis (occupational lung disease); organ transplant recipient.

---The Center for Disease Control and Prevention, the American College Health Association, and the United States Public Health Service recommend that tuberculosis skin testing be performed on all individuals who may be at risk of tuberculosis.

Do any of the Sections above apply to you?

Yes, if yes, a TB test is required through a PPD skin test, IFGA, or chest radiography.

No, if no, you are not required to have the TB/PPD test*

Section 4: If you were born in or in the last 5 years, you have lived or traveled for 30 days or more in any of the following Areas with a High Prevalence of Tuberculosis as defined by the World Health Organization and the PA State Health Department (please check on the link below for list of high risk countries within the regions):

- Tuberculosis in WHO regions
  - African Region
  - Region of the Americas
  - South-East Asian Region
  - European Region
  - Eastern Mediterranean Region
  - Western Pacific Region

*Some majors require a Tuberculosis test to be completed regardless of risks above. Please check with your major department.

Student Signature: __________________________ Date: __________________________

For University Use: □ Reviewed

Signature of University Practitioner/ Date: __________________________

Rev. Jan 2015
**Practitioner’s Report**

Please review Student Health History (Page 1) and complete this page (Page 2). This student has been admitted; this information will be used as background to provide proper health care if necessary.

**Physician/provider to complete if at risk for Tuberculosis (see screening answers on page 1):**

<table>
<thead>
<tr>
<th>Tuberculin Skin Test:</th>
<th>Date Given: / /</th>
<th>Signature: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Date Read: / /</td>
<td>Signature: ____________________________</td>
</tr>
</tbody>
</table>

**If positive, must provide:** Chest Radiography within 2 years (attach a copy of x-ray report)

**OR**

- IGRA Results

**MANDATORY IMMUNIZATIONS**

To be completed and signed by a health care provider OR attach copy of immunization history (must include mandatory immunizations below)

<table>
<thead>
<tr>
<th>MMR (measles, Mumps, Rubella)</th>
<th>MMR titers</th>
<th>Tetanus-Diphtheria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dose 1 – Immunized at 1 year of age or after</td>
<td>/ / / /</td>
<td>(Td or Tdap within last 10 years)</td>
</tr>
<tr>
<td>Dose 2 – At least 4 weeks after dose 1</td>
<td>/ / / /</td>
<td>Td / / / or</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other immunizations recommended:</th>
<th>Hep B series</th>
<th>Varicella #1 #2 #3</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Meningococcal Vaccine</th>
<th>Meningococcal waiver:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(at least one dose after 16 is recommended)</td>
<td>I, ____________________________, received and reviewed the information provided by Millersville 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.</td>
</tr>
<tr>
<td>Date / / / / dose 1</td>
<td>Signature of student (guardian if student is not 18)</td>
</tr>
<tr>
<td>Date / / / / dose 2</td>
<td>Date</td>
</tr>
</tbody>
</table>

**Physical Examination:** (to be completed by Practitioner)

- Allergies: ____________________________ NKA □
- Current Medications: ____________________________ None □
- B/P: / / Pulse: _______ Height: _______ Weight: _______ Corrected Vision: Right 20/____ Left 20/____
- Past surgeries/Hospitalizations: Yes □ No □ Please list: ____________________________
- Other pertinent history: ____________________________

**Organ System**

<table>
<thead>
<tr>
<th>Abnormal</th>
<th>Normal</th>
<th>Abnormal</th>
<th>Normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head, Ears, Nose, and Throat</td>
<td>Genitourinary – Hernia (Males)</td>
<td>Musculoskeletal</td>
<td>Metabolic/Endocrine</td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
<td>Respiratory</td>
<td>Neuropsychiatric</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gastrointestinal</td>
<td>Skin</td>
</tr>
</tbody>
</table>

(Please use additional sheet for comment/explanation if necessary)

- Is there any loss or serious impaired function of any paired organ? Yes □ No □ Comment: ____________________________
- Is the patient currently under treatment for any medical or emotional condition? Yes □ No □ Comment: ____________________________
- Do you have any recommendations regarding the care of this individual? Yes □ No □ Comment: ____________________________
- Recommendations for physical activity (PE, intramurals, ROTC, etc.) Limited □ Unlimited □ Comment: ____________________________

**Practitioner’s Name (print):** ____________________________

**Office address:** ____________________________

**Phone:** ____________________________

**Fax:** ____________________________

**Practitioner’s Signature:** ____________________________

**License Number:** ____________________________

**Date:** ____________________________

Rev. Jan 2015