



## Millersville University Health Services Checklist

The following information/record must be **completely** filled out and submitted to Health Services by August 1 (fall session) and by January 1 (spring session). All students must submit a copy of this health record to Health Services even if he/she is required to submit his/her health record to the Athletic Department, The Nursing Department, ROTC or International Studies.

Failure to submit a completed health record to Health Services will result in the inability of the student to register for subsequent semester classes and/or the receipt of class grades.

Health Services advises you to keep a copy of these forms for your records.

- Completed Medical Practitioners Report of Health (within past 12 months for freshman students or 36 months for transfer/graduate students)
- Completed Tuberculosis Screening, with appropriate follow-up as indicated
- Signed HIPAA Consent
- Completed Immunization Record
  - Required Vaccinations
    - DPT (Diphtheria/Tetanus/Pertussis) Booster within the last ten (10) years
    - MMR (Measles/Mumps/Rubella) two doses, or positive titers
    - Meningitis vaccination or signed waiver for residential students
- Completed Report of Medical History

**\*\*Be sure to carry your health insurance card (or legible copy of front and back) to school in case of an emergency requiring hospitalization or diagnostic testing.**

To the Examining Practitioner: Please review the student's history, complete and sign all forms as indicated. Please comment on all positive answers to help us better care for this individual. This individual has been accepted; the information within these forms will not affect his or her status.

All blanks must be completed by answering "yes" or "no" or by supplying the information requested. Unanswered questions or incomplete answers will require that the form be returned for completion.

**This report is confidential and should be mailed or faxed by the individual or practitioner directly to: Millersville University Health Services, Witmer Building, P.O. Box 1002, Millersville, PA 17551-0302. Fax: 717-871-2243.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Student ID Number (if known): \_\_\_\_\_  Male  Female

B/P: \_\_\_\_/\_\_\_\_ Pulse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Corrected Vision: Right: 20/\_\_\_\_ Left: 20/\_\_\_\_

Are there any **abnormalities** of the following systems? Describe fully in area below if positive. Use additional sheet if necessary.

Organ System	Abnormal	Normal
Head, Ears, Nose or Throat		
Eyes		
Respiratory		
Cardiovascular		
Genitourinary – Hernia (males)		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Is there loss or seriously impaired function of any paired organ? No \_\_\_\_\_ Yes \_\_\_\_\_, please explain: \_\_\_\_\_

Recommendations for physical activity (PE, Intramurals, ROTC): Unlimited \_\_\_\_\_ Limited \_\_\_\_\_, please explain: \_\_\_\_\_

Is the patient now under treatment for any medical or emotional condition? No \_\_\_\_\_ Yes \_\_\_\_\_, please explain: \_\_\_\_\_

Do you have any recommendations regarding the care of this individual? No \_\_\_\_\_ Yes \_\_\_\_\_, please explain: \_\_\_\_\_

Practitioner's Signature: \_\_\_\_\_

Office Address: \_\_\_\_\_

Print Last Name: \_\_\_\_\_ Date: \_\_\_\_\_ Office Phone: \_\_\_\_\_

For University Use Only

Chart Reviewed:

\_\_\_\_\_  
Signature of University Practitioner      Date

# Tuberculosis Screening

(To be Completed by Student)

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The Centers 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 as a result of a medical condition or previous residence in a country with an increased prevalence of tuberculosis.

## Students:

Please complete the following form completely. Place a checkmark in the box in front of the section if any item in the section is true for you. **If you check any boxes in sections 1-5, you are required to have a Tuberculosis Skin Test (PPD).** A history of BCG vaccination should not preclude testing a member of a high-risk group. Check the box at the bottom of the page if sections 1-5 do not apply to you. Sign and date the form at the bottom. If you are under eighteen years of age, your parent or guardian will need to sign the form. Remember to take this form with you to your physical exam appointment; your healthcare practitioner will need this information to complete your physical exam.

- Section 1:** Check the box if you have any of the following Possible Symptoms of Tuberculosis.
  - Unexplained weight loss
  - Unexplained elevation of temperature for more than one week
  - Unexplained night sweats
  - Unexplained persistent cough for more than 3 weeks
  - Unexplained cough productive of bloody sputum
  
- Section 2:** Check the box if you have any of following Risk Factors for Tuberculosis Infection.
  - Close contact with a known case of infective 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:** Check this box if you have any of the following Risk Factors for Tuberculosis Disease.
  - Diabetes mellitus
  - Lymphoma, leukemia, or cancer of the head, neck or lung
  - Gastrectomy or jejunum-ileal bypass (gastric bypass surgery)
  - Greater than 10% below ideal body weight
  - Silicosis (occupational lung disease)
  - Organ transplant recipient
  
- Section 4:** Check this box if you are a Nursing, Respiratory Therapy or Medical Technology Major.
  
- Section 5:** Check this box 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.
  - Africa – All countries
  - Asia/Southeast Asia, Asia/Pacific Islands – All countries
  - North, Central and South America – Argentina, Bahamas, Belize, Bolivia, Costa Rica, Columbia, Dominican Republic, Ecuador, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Suriname, Venezuela
  - Europe – Belarus, Bosnia-Herzegovina, Bulgaria, Croatia, Estonia, Hungary, Latvia, Lithuania, Macedonia, Moldova, Poland, Portugal, Romania, Russian Federations, Serbia, Slovak Republic, Slovenia, Ukraine, Yugoslavia
  - Middle East – Bahrain, Iran, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, Syrian Arab Republic
  
- No,** none of the items listed in sections 1-5 apply to me.

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Student Signature (Parent/Guardian Signature if student less than 18 years of age)

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Date

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ 3

### Tuberculosis Testing

The Tuberculosis Risk Assessment must be completed by the student or parent/guardian, signed and returned with the physical form.

All nursing and medical technology students are required to have an annual PPD regardless of risk assessment. Also, a history of BCG vaccination should not preclude evaluation of a member of a high risk group.

Are any of the boxes checked in Sections 1-5 of the Tuberculosis Risk Assessment?

\_\_\_\_ No. If no, Stop; Sign below      \_\_\_\_ Yes. If yes, tuberculosis testing is required through either a PPD skin test or chest radiography

#### Tuberculin Skin Test (PPD)

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Yr

Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Yr

Result: \_\_\_\_\_ mm. (Record actual mm of induration; transverse diameter; if no induration, record "0")

Interpretation (based on induration as well as risk factors): Positive: \_\_\_\_ Negative: \_\_\_\_

#### Chest Radiography (please attach a copy of the radiography report)

Date of chest radiography: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_ Normal \_\_\_\_ Abnormal  
Mo Day Yr

Document any treatment the student has received for either a positive TB skin test or active tuberculosis Medication(s): \_\_\_\_\_

Date Started: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Yr

Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mo Day Yr

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Date

### Consent for Treatment

The undersigned herewith:

- Grants permission to Millersville University Health Services to provide medical care including administration of treatments and medications as necessary.
- Certifies that the answers to the questions on this Health Record are correct and true.

\*Parent/Guardian must co-sign if student is under age 18.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (if student under age 18)

\_\_\_\_\_  
Date

### HIPAA Consent

By signing below, I hereby acknowledge that I have downloaded a copy of Millersville University Health Services' Notice of Privacy Practices and have therefore been advised of how my protected health information may be used and disclosed by Millersville University Health Services and how I may obtain access to and control this information. In addition, by signing below, I hereby consent to the use and disclosure of my health related information for treatment purposes, payment activities and healthcare operations of Millersville University Health Services as described in the notice.

I grant permission to MU Health Services to discuss my health information with the following person(s):

\_\_\_\_\_  
Name/Relationship to Student

\_\_\_\_\_  
Name/Relationship to Student

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name



# Report of Medical History

(To be Completed by Student)

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name, relationship, and address of person to be contacted in an emergency Home telephone number

Emergency contact business address Business telephone number

**Please be sure to always carry your health insurance card (or copy of both sides) while at Millersville University in the event that you would need medical care beyond Health Services.**

## Family History

**Do any of your family members have any of the following?**

	Gender	Age	State of Health	Occupation	Age of Death	Cause of Death	Do any of your family members have any of the following?			
							Yes	No	Relationship	
Father							Diabetes			
Mother							Hypertension			
Siblings							Heart Disease/Sudden Cardiac Death before age 50			
							Thyroid Disease			
							Cancer			
							Epilepsy, Convulsions			
							Sickle Cell Disease			
							Kidney Disease			

**Personal History – Please answer all questions. Comment on all positive answers in space provided below.**

Have You Had?	Yes	No		Yes	No		Yes	No
<b>Eyes:</b>			<b>Cardiovascular:</b>			<b>Endocrine:</b>		
- Visual Disturbances			- Chest Pain			- Diabetes		
- Corrective Lenses			- Palpitations			- Thyroid Problems		
			- High/Low Blood Pressure					
<b>Ear, Nose, Throat:</b>			<b>Gastrointestinal:</b>			<b>Neurological/Psychological:</b>		
- Hearing Loss			- IBS			- Dizziness/Fainting		
- Nose Bleeds			- GERD			- Headaches		
- Allergic Rhinitis			- Celiac Disease			- Anxiety/Depression		
			- Diarrhea/Constipation			- Insomnia		
<b>Respiratory:</b>						- ADD/ADHD		
- Asthma			<b>Urinary:</b>			- Seizures		
- Chronic Cough			- Sexually Transmitted Infection					
			- Urinary Tract Infections			<b>Social:</b>		
<b>Skin:</b>			- Hernias			Tobacco Use		
- Rashes						Alcohol Use		
- Skin Lesions			<b>Gynological:</b>			Learning Disability		
			- Severe Cramps			“Street” Drugs		
<b>Musculoskeletal:</b>			- Irregular Periods					
- Back/Joint Pain			- Breast Problems			Current or Past Military Service		
- Muscle Pain/Weakness								

Medication Allergies (please list, if any): \_\_\_\_\_

Prior Surgeries/Hospitalizations (please list, if any): \_\_\_\_\_

Other Pertinent Health History: \_\_\_\_\_

Student Signature

Date

Practitioner Signature (Acknowledging Review)

Date