Dear Student,

Congratulations on your acceptance to Millersville University! In order to provide students with high quality medical care, Millersville University Health Services (MUHS) requires the following information.

Please document your health information on the Health Evaluation form which can be downloaded and printed from our website at [http://millersville.edu/healthservices/](http://millersville.edu/healthservices/). Complete the Student Health History portion yourself (Page 1) and then have your healthcare provider complete the Physician’s Report (page 2).

**The Student Health History to be completed by you, the student, includes:**
1. Family History
2. Personal medical history
3. Risk factors for Tuberculosis, and screening requirements

**The Physicians Report to be completed by your healthcare provider includes:**
1. Tuberculosis test (PPD) documentation is required by Health Services only if student indicates risk factors on Tuberculosis Screening section of the Student Health History.
2. Immunization Records
   * Required Vaccinations for all students:
     - Td (Tetanus/Diphtheria) OR Tdap (Tetanus/Diphtheria/Pertussis)- Booster within the last ten (10) years
     - MMR (Measles/Mumps/Rubella) Two doses, or report of positive titers
   * On-campus Residential Students are also required to have:
     - Meningitis vaccination or signed waiver
3. A 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).

Please mail completed forms to:

Millersville University Health Services OR fax to: 717-871-5252
PO Box 1002
Millersville, PA 17551

If you have any questions regarding the Health Evaluation form or these requirements, please contact Health Services at (717) 871-5250, hservices@millersville.edu, or visit the website listed above.

**Please remember that completion of both pages of the Health Evaluation form is required.**

**Deadlines are:** January 1st for Spring and August 1st for Fall. If you fail to submit the Health Evaluation form or submit incomplete medical documentation, you will be contacted via phone, email, or it may be returned to you and a hold will be placed on your student record preventing you from registering for future classes. Thank you for your cooperation.

Millersville University promotes the overall wellness of each student enrolled. We look forward to meeting you. The staff at Health Services and I hope you find your Millersville University experience rewarding and enlightening.

Sincerely,

Susan F. Northwall, DO.
Medical Director, Health Services
Millersville University
Student Health History

STUDENT: Please complete page 1 prior to your appointment with your Practitioner. Please 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 - Have you ever had any of the below? If yes, please comment on all positive answers in the space provided below.

- Biological Family Member
  - Father
  - Mother
  - Sibling M / F
  - Sibling M / F
  - Sibling M / F

- If Deceased: Cause of death
- Age at death
- Do you or any of your biological family members have:
  - Cancer
  - Diabetes
  - Epilepsy, Seizures
  - Hypertension
  - Heart Disease
  - 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.

- Allergies:
  - Material goods/Food
  - Cardiovascular:
    - Asthma
    - Heart Murmur
    - High Blood Pressure
    - Low Blood Pressure
    - Sibling
- Respiratory:
  - Cough/Constitution
  - History of head injury

- Eyes:
  - Visual Disturbances
  - Dizziness/Fainting

- Neurological/Psychological:
  - Frequent Headaches
  - Skin Lesions

- Skin:
  - Rashes
  - Skin Lesions

- Other:
  - Tobacco Use
  - Current or Past Military Service?

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 jejuno-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*

*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

Page 1

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):**

- Tuberculin Skin Test: [Date Given] [Date Read] [Signature] [Result mm - Positive: [ ] Negative [ ]]
  - If positive, must provide: Chest Radiography within 2 years (attach a copy of x-ray report)
  - IFGA 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>Option 1</th>
<th>MMR titer</th>
<th>Tetanus-Diphtheria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose 1 - Immunized at 1 year of age or after</td>
<td>[ ]</td>
<td>Date of titer [ ]/ [ ]/ [ ]</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>
<td>Td [ ]/ [ ]/ [ ] or Tdap [ ]/ [ ]/ [ ]</td>
</tr>
</tbody>
</table>

- **Option 2**
  - A copy of the titer results must be attached
  - (“*if not positive, will need vaccinations)

**Other immunizations recommended:**

- Hep B series #1 [ ]/ [ ]/ [ ] #2 [ ]/ [ ]/ [ ] #3 [ ]/ [ ]/ [ ]
- Varicella #1 [ ]/ [ ]/ [ ] #2 [ ]/ [ ]/ [ ]
- HPV #1 [ ]/ [ ]/ [ ] #2 [ ]/ [ ]/ [ ] #3 [ ]/ [ ]/ [ ]

**Meningococcal Vaccine**

Pennsylvania State law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unit unless the vaccination against meningococcal disease has been received, or a student (parent or guardian for minors) may sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Please review the links below for information and risk for meningitis.

http://www.cdc.gov/meningococcal/about/risk.html
http://www.cdc.gov/meningitis/bacterial.html

**Meningococcal waiver:**

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.

______________________________
Signature of student (guardian if student is not 18)

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

- Allergies: [ ] NKA [ ] Current Medications: [ ] None [ ]
- B/P [ ]/ [ ] Pulse: [ ] Height: [ ] Weight: [ ] Corrected Vision: Right [ ]/ [ ] Left [ ]/ [ ]
- Past surgeries/Hospitalizations: Yes [ ] No [ ] Please list: ____________________________________________________________

**Organ System**

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