MU Health Services

Division of Student Affairs & Enrollment Management

Millersville University Health Services
4 McCollough Street, PO Box 1002
Millersville, PA 17551
717-871-5250 Fax: 717-871-7926

Dear Student,

Congratulations on your acceptance to Millersville University! Health Services requires a **Health Evaluation Form** to be completed. This form can be mailed, faxed or e-mailed to:

Millersville University Health Services
Witmer Building
PO Box 1002
Millersville, PA 17551
Fax # 717-871-7926
e-mail: hservices@millersville.edu

Instructions for completing the Health Evaluation Form:

The Student Health History portion, to be completed and signed by the student includes:

1. Family history
2. Personal medical history
3. Risk factors for Tuberculosis (TB) Screening Questionnaire
4. Student Signature

The Practitioner's Report, to be completed and signed by your healthcare provider includes:

1. Tuberculosis test (PPD) documentation **only if** student indicates risk factors on the TB Screening section of the Student Health History.
2. Record of Current Immunizations must be provided.
   * Required Vaccinations for all students include:
     - **Td or Tdap** – Booster within the last 10 years
     - **MMR** (Measles/Mumps/Rubella) **2 doses**, or report of positive titers
   * Students living on-campus are required to have Meningitis vaccination or sign the waiver on the immunization section.
3. A **physical examination** (within the past 12 months of admission for freshman students and within 36 months of admission for transfer and graduate students).

Completed Health Evaluation Form must be submitted to Millersville University Health Services

by August 1st for Fall admission
by January 1st for Spring admission

Failure to submit the Health Evaluation Form or submission of incomplete medical documentation may result in a hold on your student record preventing you from registering for future classes.

If you have any questions regarding the Health Evaluation form or these requirements, please contact Health Services at 717-871-5250, or visit our website at www.millersville.edu/healthservices/

Millersville University strives to promote the overall wellness of every student. The staff at Health Services look forward to meeting you. We hope you find your Millersville University experience rewarding and enlightening.

Sincerely,

Millersville University Health Services

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STUDENT: Please complete page 1

MU ID # _____

Name: _____ Preferred Name (if applicable): _____ Date of Birth: _____

Gender at Birth: F ____ M ____ Gender Identity (if different from birth): _____ Cell Phone: _____

Perm. (Home) Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: Name: _____ Phone #: _____ Relation: _____

Do you have Health Insurance? _____ Yes _____ No

Health Insurance Name: _____ Policy ID # _____ Policy Holder: Self ___ Parent ___

STUDENT HEALTH HISTORY

Family History:

Biological Family Member	Age	State of Health	If Deceased: Cause of Death	Age at Death
Father				
Mother				
Sibling M / F				
Sibling M / F				
Sibling M / F				
Sibling M / F				
Sibling M / F				

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

	Yes	No	Relationship
Cancer			
Diabetes			
Epilepsy/Seizures			
Heart Disease			
-Sudden Cardiac Death before age 50			
Hypertension			
Mental Health History			
Sickle Cell Disease			
Thyroid Disease			

Personal Medical History: Please comment on all positive answers in the space provided below.

	Yes	No		Yes	No		Yes	No		Yes	No
Eyes:			**Respiratory:**			**Endocrine:**			**Allergies:**		
- Visual Disturbances			- Asthma			- Diabetes			- Material Goods / Foods		
- Corrective Lenses			- Chronic Cough			- Thyroid Problems			**Gynecological:**		
Ear, Nose, Throat:			**Musculoskeletal:**			**Neurological/Psychological:**			- Severe Cramps		
- Seasonal Allergies			- Chronic Back/Joint Pain			- Dizziness/Fainting			- Irregular Periods		
- Hearing Loss			- Chronic Muscle Weakness			- Frequent Headaches			- Breast Problems		
Cardiovascular:			- Chronic Muscle Pain			- Anxiety			**Urinary:**		
- Heart Problems			**Gastrointestinal:**			- Depression			- Sexually Transmitted Infection		
- Heart Murmur			- IBS			- ADD/ADHD			- Urinary Tract Infections		
- Bleeding Disorder			- GERD			- Insomnia			- Hernia		
- High Blood Pressure			- Celiac Disease			- History of Concussion			**Other:**		
- Low Blood Pressure			- Diarrhea/Constipation			- Seizures			-Tobacco Use		
- Sickle Cell Disease/Trait			**Skin:**			-Autism Spectrum Disorder			-Alcohol Use		
			- Rashes						-"Street" Drugs		
			- Skin Lesions						-Learning Disability		

Comments:

Tuberculosis Screening: (please circle any risk factors that apply in each section)

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 infective tuberculosis; use of illegal injected drugs; HIV 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, nect or lung; gastrectomy or gastric bypass surgery; greater than 10% below ideal body weight; silicosis (occupational lung disease); organ transplant recipient.

Section 4: If you were born in or in the last 5 years, you have traveled for 30 da days or more in any of the following Areas with a High Prevalence of TB as defined by the World Health Organization and the PA State Health Dept.

- Check on the link below for list of high risk countries within the regions: https://www.who.int/tb/country/data/profiles/en/

Tuberculosis in WHO regions:

- African Region
- Region of the Americas
- South-East Asian Region
- European Region
- Eastern Mediterranean Region
- Western Pacific Region

--The Center for Disease Control and Prevention, the American College Health Association, and the US 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 PPD skin test, IFGA test, or Chest x-ray is required.

_____ No. If no, no TB/PPD test is required. *

* Some majors may require a tuberculosis test to be completed regardless of risk factors above. Please check with your department major.

Student Signature: _____ Date: _____

For University Use: Reviewed by: _____ Date: _____

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Name: _____ DOB: _____

PRACTITIONER'S REPORT

Provider to complete (if a risk for Tuberculosis (refer to screening answers on page 1)

Tuberculin Skin Test: Date Given _____/_____/_____ Date Read _____/_____/_____

Results _____mm Positive _____ Negative _____

If positive, must provide: Chest X-ray within 2 years (attach a copy of x-ray report) **OR** IFGA Results _____

Documentation is required if treatment received for: ☐ positive TB skin test, or ☐ abnormal chest x-ray, or ☐ active tuberculosis

Medication _____ Date Started _____/_____/_____ Date Completed _____/_____/_____

MANDATORY IMMUNIZATIONS

To be completed by a health care provider or **Attach copy of immunization history** (must include mandatory immunizations below)

MMR (measles, Mumps, Rubella)		**MMR**	**Tetanus-Diphtheria**
Option 1		**Titer Option 2**	(within last 10 years)
Dose 1 – Immunized at 1 year of age or after ____/____/____	**OR**	Date of titer____/____/____	Td ____/____/____
Dose 2 – At least 4 weeks after dose 1 ____/____/____		**A copy of the titer results must be attached** (**if not positive, will need vaccinations)	OR Tdap ____/____/____

Other immunizations recommended: **Hep B series** #1___/___/___#2_____/___/___#3_____/___/___

Varicella #1___/___/___**#2**____/___/___**OR** Disease Date ____/____/____ **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-community.html http://www.cdc.gov/meningitis/bacterial.html

Meningococcal Vaccine (Menactra/Menveo)		**Meningitis B Vaccine (Bexsero/Trumenba)**
Date___/___/___#1	**OR**	Date___/___/___#1
Date___/___/___#2		Date___/___/___#2

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) Date

If vaccine has not been received, the waiver MUST be signed by student/guardian if in campus housing

Physical Examination: (to be completed and signed 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	**Normal**	**Abnormal/Comment**		**Normal**	**Abnormal/Comment**
Head, Ears, Nose, and Throat			Genitourinary – Hernia (Males)		
Eyes			Musculoskeletal		
Respiratory			Metabolic/Endocrine		
Cardiovascular			Neuropsychiatric		
Gastrointestinal			Skin		

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

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:**
Practitioner's Signature:		**Fax:**
	License Number:	**Date:**