STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY

CHECK LIST

This health record must be COMPLETELY filled out and submitted to the Student Health Center by July 1st. All students must submit a copy of this health record to the Student Health Center even if he/she is required to submit his/her health record to the Athletic Department, the Nursing School or ROTC programs.

Please make **two additional copies** of your health record forms: One for your records at home and one for you to keep in your possession at school in the event you participate in intramural or club sport activities.
DO NOT SEND THE TWO ADDITIONAL COPIES TO THE STUDENT HEALTH CENTER

☐ Completed Health Record: Medical History, Medications, Allergies.

☐ Required immunizations documented on Villanova Health Record.
NO ATTACHMENTS

☐ **Tuberculosis screening: (PPD/Mantoux) – date and results (within the last 365 days) <u>OR</u> Quantiferon Gold TB test date required.**

☐ **A second Meningitis (Men ACWY) vaccination is required if you received your first shot before the age of 16.**

☐ **Dates of Meningitis B (Bexsero or Trumenba)**

☐ Documented physical exam within 365 days **prior to the start of incoming freshmen orientation.**

☐ **Two** additional copies of the Student Health Record. One for your records at home and one for you to keep in your possession at school.

☐ Bring a copy of your insurance card to school in case of an emergency requiring hospitalization, x-ray, etc.

PLEASE SEND THE HEALTH RECORD IN AS ONE COMPLETE PACKET.

FAILURE TO SUBMIT A COMPLETED HEALTH RECORD TO THE HEALTH CENTER WILL RESULT IN THE INABILITY OF THE STUDENT TO REGISTER FOR SECOND SEMESTER CLASSES.

STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY

CONFIDENTIAL

800 Lancaster Avenue • Villanova, PA 19085-1699
Phone: (610) 519-4070 • Fax: (610) 519-4047

****COMPLETED FORMS DUE BACK TO THE HEALTH CENTER BY JULY 1st**
Failure to submit a completed Health Record will result in the inability to register for 2nd semester classes.

Once your physician has completed and signed pages 4, 5, and 6 the form may be delivered, mailed, or faxed.

CONTACT INFORMATION

Name: _____
Last *First* *Middle*

Student ID: _____ **Date of Birth:** _____

College you are entering: _____ **Class of:** _____

Gender: _____ **Entrance Date:** _____

Home Address: _____
Number *Street*

_____
City *State* *Zip Code* *Country*

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Parent's Email Address: _____

Please list up to three people whom we can contact in case of emergency:

Name	*Relationship*	*Home phone*	*Work/cell phone*

ALLERGIES

Do you have any allergies to the following?		Foods		Latex		Medications
Please specify:						
Will you be receiving allergy injections at the Student Health Center?		Yes		No		

Name: _____ **Student ID #:** _____

MEDICAL HISTORY

Indicate below if you have *ever* experienced any of these problems, please circle "Yes."
If you are *currently* experiencing any of these problems, please circle "Currently."

EYE

Corrective Lenses/Contacts	Yes	Currently
Other Problems	Yes	Currently
Other		
Remarks		

ENT

Ear Problems	Yes	Currently
Other		
Remarks		

HEART DISEASE

High Blood Pressure	Yes	Currently
Palpitations	Yes	Currently
Heart Murmur	Yes	Currently
Other		
Remarks		

RESPIRATORY

Shortness of Breath	Yes	Currently
Asthma	Yes	Currently
Bronchitis	Yes	Currently
Other		
Remarks		

ABDOMINAL

Irritable Bowel Syndrome	Yes	Currently
Inflammatory Bowel Disease	Yes	Currently
Other		
Remarks		

ENDOCRINE

Diabetes	Yes	Currently
Thyroid	Yes	Currently
Other		
Remarks		

URINARY

Kidney Stones	Yes	Currently
Urinary Tract Infections	Yes	Currently
Other		
Remarks		

MUSCULOSKELETAL

Back Problems	Yes	Currently
Disease or Injury of Joints	Yes	Currently
Other		
Remarks		

HEMATOLOGICAL/ ONCOLOGICAL

Anemia	Yes	Currently
Cancer	Yes	Currently
Other		
Remarks		

NEUROLOGICAL/PSYCHOLOGICAL

Seizures	Yes	Currently
Headaches	Yes	Currently
Depression	Yes	Currently
Anxiety	Yes	Currently
Eating Disorder	Yes	Currently
Other		
Remarks		

GYNECOLOGICAL

Irregular Periods	Yes	Currently
Severe Cramps	Yes	Currently
Ovarian Cyst	Yes	Currently
Other		
Remarks		

FAMILY HISTORY – Circle all that apply

Mother			***Father***		
Living Deceased	High Blood Pressure	Heart Disease	Living Deceased	High Blood Pressure	Heart Disease
Diabetes	Thyroid Disease	Cancer	Diabetes	Thyroid Disease	Cancer
Other (specify):			Other (specify):		
Occupation:			Occupation:		

Name: _____ **Student ID #:** _____

REQUIRED IMMUNIZATIONS

NO ATTACHMENTS PLEASE

VACCINE	DATE (MM/DD/YY)	DATE (MM/DD/YY)
MENINGOCOCCAL MEN ACWY CIRCLE: Menactra/Menveo	/ /	DATE MUST BE ON OR AFTER AGE 16
SEROGROUP B MENINGOCOCCAL CIRCLE: Bexsero/Trumenba	#1 / /	#2 / /
TETANUS TDAP (Required within last 10 years)	/ /	
HEP B SERIES	#1 / /	#2 / / #3 / /
MMR SERIES	#1 / /	#2 / /
or		
MEASLES	#1 / /	#2 / /
MUMPS	#1 / /	#2 / /
RUBELLA	#1 / /	#2 / /
POLIO VACCINE – IPV/OPV (Last date of completed primary series)	/ /	
MUST HAVE TWO VACCINES **VARICELLA #1**	#1 / /	#2 / /
or		
CHICKEN POX DISEASE	/ /	
TUBERCULOSIS SCREENING - MANTOUX /PPD (within past 365 days)	/ /	REACTIVE YES NO (please circle) _____ mm ***If result is positive, a Quantiferon Gold TB blood test is required.
or		
QUANTIFERON GOLD	/ /	RESULTS:
or		
LOW RISK TESTING NOT INDICATED	/ /	

PLEASE HAVE HEALTH CARE PROVIDER INTITAL OR STAMP

NAME:_____ STUDENT ID #: _____

STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY
NON-REQUIRED IMMUNIZATION RECORD

VACCINE	DATE (MM/DD/YY)
BCG	/ /
HEP A #1	/ /
HEP A #2	/ /
HPV #1 (GARDASIL)	/ /
HPV #2 (GARDASIL)	/ /
HPV #3 (GARDASIL)	/ /
TYPHOID	/ /
YELLOW FEVER	/ /

STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY
CLINICIAN'S FORM

CONFIDENTIAL

800 Lancaster Avenue • Villanova, PA 19085-1699
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Patient's Name: _____ **Student ID. #:** _

TO THE EXAMINING CLINICIAN

Please review the patient's history, complete the clinician's form and comment on all positive answers.

BP	/	**Height**		**Weight**	

Physical Exam:

Eyes	WNL	Remarks:	
Ears	WNL	Remarks:	
Nose	WNL	Remarks:	
Throat	WNL	Remarks:	
Neck	WNL	Remarks:	
Lungs	WNL	Remarks:	
Heart	WNL	Remarks:	
Abdomen	WNL	Remarks:	
Lymph glands	WNL	Remarks:	
G.U.	WNL	Remarks:	
Skin	WNL	Remarks:	
Neuro	WNL	Remarks:	
Musculoskeletal	WNL	Remarks:	

CURRENT MEDICATIONS: (REQUIRED)

_____

_____

Is this patient medically qualified to participate in intercollegiate, intramural or club sport activities? **Yes** **No**

Clinician's Signature _____ Date exam was completed _

Clinician's *Printed* Name _____

Clinician's Address _____

Clinician's Phone # _____ Fax # _____

Villanova University Health Center

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Pennsylvania state law (specifically 35 p.s. Section 10101) requires any minor who is eighteen (18) years of age or older, or has graduated from high school, or has married, or has been pregnant, may give effective consent to medical, dental and health services for himself or herself, and the consent of no other person shall be necessary.

I hereby consent to and authorize the health center to release information about my medical condition to my parents/legal guardian.

Purpose of the Disclosure:

The information may be released in order to keep my parents/legal guardians informed about my general health and medical condition.

I authorize disclosure to my parents/legal guardians of all information contained in my medical records.
My authorization may be revoked at any time.

Signature _____

Printed Name _____

Student ID # _____

Date _____

The Student Health Center does not bill insurance companies. We do request that you send front and back copies of insurance and prescription cards with the health record. This information will be kept on file for emergency use only (i.e. emergency room visit or hospitalization).

Form revised: 1-18-19