

**STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY**

CHECKLIST

This health record must be COMPLETELY filled out and submitted to the Student Health Center by Thursday, July 1, 2021. All students must submit a copy of this health record to the Student Health Center even if they are required to submit their 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 the Villanova Health Record. **NO ATTACHMENTS**
- Tuberculosis screening: (PPD/Mantoux) – date and results (within the last 365 days) OR 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)**
- Date/s of COVID-19 vaccine**
- Documented physical exam within 365 days **prior to the start of New Student 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 1.**

Failure to submit a completed Health Record will result in the inability to register for second 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?	<input type="checkbox"/>	Foods	<input type="checkbox"/>	Latex	<input type="checkbox"/>	Medications
Please specify:						
Will you be receiving allergy injections at the Student Health Center?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	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			URINARY		
Corrective Lenses/Contacts _____	Yes	Currently	Kidney Stones _____	Yes	Currently
Other Problems _____	Yes	Currently	Urinary Tract Infections _____	Yes	Currently
Other _____			Other _____		
Remarks _____			Remarks _____		
ENT			MUSCULOSKELETAL		
Ear Problems _____	Yes	Currently	Back Problems _____	Yes	Currently
Other _____			Disease or Injury of Joints _____	Yes	Currently
Remarks _____			Other _____		
			Remarks _____		
HEART DISEASE			HEMATOLOGICAL/ ONCOLOGICAL		
High Blood Pressure _____	Yes	Currently	Anemia _____	Yes	Currently
Palpitations _____	Yes	Currently	Cancer _____	Yes	Currently
Heart Murmur _____	Yes	Currently	Other _____		
Other _____			Remarks _____		
Remarks _____					
RESPIRATORY			NEUROLOGICAL/PSYCHOLOGICAL		
Shortness of Breath _____	Yes	Currently	Seizures _____	Yes	Currently
Asthma _____	Yes	Currently	Headaches _____	Yes	Currently
Bronchitis _____	Yes	Currently	Depression _____	Yes	Currently
Other _____			Anxiety _____	Yes	Currently
Remarks _____			Eating Disorder _____	Yes	Currently
			Other _____		
			Remarks _____		
ABDOMINAL			GYNECOLOGICAL		
Irritable Bowel Syndrome _____	Yes	Currently	Irregular Periods _____	Yes	Currently
Inflammatory Bowel Disease _____	Yes	Currently	Severe Cramps _____	Yes	Currently
Other _____			Ovarian Cyst _____	Yes	Currently
Remarks _____			Other _____		
			Remarks _____		
ENDOCRINE					
Diabetes _____	Yes	Currently			
Thyroid _____	Yes	Currently			
Other _____					
Remarks _____					

FAMILY HISTORY – Circle all that apply

<i>Mother</i>				<i>Father</i>			
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: _____			

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 / / #3 (If applicable) / /
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 <u>365</u> 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 INITIAL OR STAMP

NAME: _____

STUDENT ID #: _____

**STUDENT HEALTH CENTER
VILLANOVA UNIVERSITY
COVID-19 VACCINE**

VACCINE	DATE (MM/DD/YY)	DATE (MM/DD/YY)
MODERNA	#1 / /	#2 / /
PFIZER	#1 / /	#2 / /
JOHNSON & JOHNSON	#1 / /	N/A

**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
Phone: (610) 519-4070 • Fax: (610) 519-4047

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	
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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).