 

**Shippensburg University**

Etter Health Center

1871 Old Main Dr.

Shippensburg, PA 17257

P. (717) 477-1458 F. (717) 477-4042

Dear Student,

Congratulations on your acceptance to Shippensburg University! Etter Health Center is requesting a **Health Evaluation Form** to be completed. This form can be mailed, faxed or e-mailed to:

Etter Health Center

1871 Old Main Dr.

Shippensburg, PA 17257

Fax: (717) 477-4042 e-mail: [etter@ship.edu](mailto:etter@ship.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 should be submitted to Shippensburg University Etter Health Center**

If you have any questions regarding the Health Evaluation form or these requirements, please contact Etter Health Center at (717) 477-1458.

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

Sincerely,

Etter Health Center

Etter Health Center

1871 Old Main Dr.

Shippensburg, PA 17257

P. (717) 477-1458 F. (717) 477-4042

**STUDENT: Please complete page 1**

SU ID **#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** SU Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender at Birth: F/M Gender Identity (if different from birth): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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\_\_\_\_\_

Name of Subscriber/Date of Birth of Subscriber if not self:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STUDENT HEALTH HISTORY**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Family History: Do any of your biological family members have any of the following?** | | | | | | | |
| **Biological Family Member** | **Age** | **State of Health** | | | **If Deceased: Cause of Death** | | **Age of Death** |
| Father |  |  | | |  | |  |
| Mother |  |  | | |  | |  |
| Sibling M/F |  |  | | |  | |  |
| Sibling M/F |  |  | | |  | |  |
| Sibling M/F |  |  | | |  | |  |
| Sibling M/F |  |  | | |  | |  |
| Sibling M/F |  |  | | |  | |  |
| **Diagnosis** | | | **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** |
| **Visual Disturbances** |  |  | **IBS** |  |  | **Insomnia** |  |  |
| **Corrective Lens** |  |  | **GERD** |  |  | **History of Concussion** |  |  |
| **Seasonal Allergies** |  |  | **Celiac Disease** |  |  | **Seizures** |  |  |
| **Hearing Loss** |  |  | **Diarrhea** |  |  | **Autism Spectrum Disorder** |  |  |
| **Heart Murmur** |  |  | **Constipation** |  |  | **Allergies (medications/food)** |  |  |
| **Bleeding Disorder** |  |  | **Rashes** |  |  | **Irregular Menstrual Periods** |  |  |
| **High Blood Pressure** |  |  | **Skin Lesions** |  |  | **Severe Menstrual Cramping** |  |  |
| **Low Blood Pressure** |  |  | **Diabetes** |  |  | **Breast Problems** |  |  |
| **Sickle Cell Disease** |  |  | **Thyroid Problems** |  |  | **Sexually Transmitted Infection** |  |  |
| **Fatigue** |  |  | **Dizziness** |  |  | **Urinary Tract Infection** |  |  |
| **Asthma** |  |  | **Fainting** |  |  | **Hernia** |  |  |
| **Chronic Back Pain** |  |  | **Frequent Headaches** |  |  | **Tobacco Use** |  |  |
| **Chronic Joint Pain** |  |  | **Anxiety** |  |  | **Alcohol Use** |  |  |
| **Chronic Muscle Pain** |  |  | **Depression** |  |  | **Street Drug Use** |  |  |
| **Chronic Muscle Weakness** |  |  | **ADD/ADHD** |  |  | **Learning Disability** |  |  |

**Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Shape

**For University Use: Reviewed by:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRACTITIONER’S REPORT**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Provider to complete (if a risk for Tuberculosis based on previous pages of this form)  Tuberculin Skin Test: Date Given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date Read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: \_\_\_\_\_\_\_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, Abnormal chest x-ray, or active Tuberculosis infection that is currently being treated- medication: \_\_\_\_\_\_\_\_\_\_\_ Date Started: \_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Immunizations**  To be completed by a health care provider or attach a copy of immunization record | | | | | | | | |
| **MMR (Measles, Mumps, Rubella)**  **Option 1**  **Dose 1: Immunized at 1 year of age or after \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  **Dose 2: At least 4 weeks after dose 1 \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_** | | **MMR**  **Titer Option 2**  **Date of titer: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **A copy of the titer results must be attached (if titers are not positive, will need vaccinations)** | | | | | **Tetanus-Diphtheria**  **(Within last 10 years)**  **Td \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_**  **Or**  **Tdap \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_** | |
| **Other immunizations recommended: Hep B series #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_**  **Varicella #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ 0r 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 link for information and risk for meningitis.** <https://www.cdc.gov/meningitis/index.html> | | | | | | | | |
| **Meningococcal Vaccine**  **Date #1 \_\_\_/\_\_\_/\_\_\_ Date #2 \_\_\_/\_\_\_/\_\_\_** | | **Meningitis B Vaccine**  **Date #1 \_\_\_/\_\_\_/\_\_\_ Date #2 \_\_\_/\_\_\_/\_\_\_** | | | | | **Meningococcal Waiver**  **I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ received and reviewed the information provided 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 under 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 a 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, & Throat |  |  | | | Genitourinary- Hernia (Males) | |  |  |
| Eyes |  |  | | | Musculoskeletal | |  |  |
| Respiratory |  |  | | | Metabolic/Endocrine | |  |  |
| Cardiovascular |  |  | | | Neuropsychiatric | |  |  |
| Gastrointestinal |  |  | | | Skin | |  |  |
| (Please use additional sheet for comments/explanations 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ License Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |