



Student Health Center
4201 Henry Avenue
Philadelphia, PA 19144-5497

Must Read Instructions:

- 1. Save the attached envelope to mail your completed health form. ALL FOUR PAGES MUST BE COMPLETED.
2. Provider must sign physical and immunization record.
3. Original Student Health Medical Record must be mailed. Faxes and copies will not be accepted.
4. Titters are the only attachments accepted.

PERSONAL IDENTIFICATION

Entering Philadelphia University: \_\_\_\_\_
Month Year

Program of Study: \_\_\_\_\_

Undergrad \_\_\_\_\_ Graduate Student \_\_\_\_\_

Student ID Number: \_\_\_\_\_

Name \_\_\_\_\_
(last, first, middle)

\_\_\_\_\_
(Home address number and street)

City State Zip Code Country

Cell Phone (Student): \_\_\_\_\_

Email Address (Student): \_\_\_\_\_

Father's Name: \_\_\_\_\_
(last, first)

Mother's Name: \_\_\_\_\_
(last, first)

Sex: [ ] Male [ ] Female

Race: [ ] Caucasian [ ] Black [ ] Asian [ ] Other

Citizenship: [ ] U.S. [ ] Other \_\_\_\_\_
(Specify)

Home Telephone Number: \_\_\_\_\_

Birth Date (Month-Day-Year): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

PERSON TO NOTIFY IN CASE OF AN EMERGENCY

Name (last, first) Relationship

Address

City State Zip Code

Country (e.g., USA, India)

Home Telephone Number

Cell Telephone Number

Business Telephone Number

HEALTH INSURANCE INFORMATION

Completing the health insurance information is optional. The online insurance waiver must still be completed unless you desire to purchase the University-sponsored plan.

This information may be faxed to a local drug store as needed. This facilitates the delivery of your prescription medication to the Student Health Center.

Please read each of the following statements and check the one that best describes your current health-medical insurance coverage. Additionally, respond to any information requested under the category.

[ ] Student has coverage through family insurance.

Insurance Company Policy Number

Insurance Company Address Group Number

Policy Holder

Insurance Company Phone Number

If the coverage is with a HMO or requires the use of a PPO, please be sure coverage is available in the Philadelphia area.

[ ] Student also has prescription coverage.

Insurance Company Policy Number

Insurance Company Address Group Number

Policy Holder

Insurance Company Phone Number

[ ] Student has coverage through a third party (e.g., Public Assistance, Medicare, etc.).

Agency Name

Agency Address

Please be sure coverage is available in the Philadelphia area.

[ ] Student has no coverage and will be only utilizing the recommended University student-health insurance.

If the following changes occur, please notify Health Services:

- Insurance coverage
• Emergency contact information

## Past Medical History

Have you had any of the following? Select “yes” or “no” to all questions about your personal medical history and briefly comment on “yes” answers in the space provided (dates, complications, etc.)

Comments:	Yes	No	Comments:	Yes	No
			Abnormal Bleeding Tendency		
			Addiction		
			Asthma		
			Cancer		
			Colitis or Colon Problems		
			Depression/Anxiety		
			Diabetes		
			Diminished Hearing		
			Eating Disorder		
			Epilepsy, Convulsions or Seizures		
			Gall Bladder or Liver Disease		
			Gastric or Duodenal Ulcer		
			Heart Condition		
			Hepatitis		
			High Blood Pressure		
			Infectious Mononucleosis		
			Kidney Disease		
			Rheumatic Fever		
			Severe Headaches		
			Severe Visual Problems		
			Thyroid Disease		
			Tuberculosis		
			Other		

### Hospitalizations

(please list date and diagnosis)

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### Surgical Procedures

(please list date and procedure)

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### List All Current Medications

(prescribed and over-the-counter)

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### Drug Allergies

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None

## PHYSICAL EXAMINATION



**TO THE EXAMINING HEALTH-CARE PROVIDER:** Please review the student's history and complete the physical examination and the immunization information. Please comment on all positive answers.

### PART I – TO BE COMPLETED AND SIGNED BY HEALTH-CARE PROVIDER.

*All information must be in English.*

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Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle name \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ lbs. BMI \_\_\_\_\_

Vision: Right 20/ \_\_\_\_\_ Corrected to 20/ \_\_\_\_\_ with  glasses  contacts

Left 20/ \_\_\_\_\_ Corrected to 20/ \_\_\_\_\_ with  glasses  contacts

### CLINICAL EVALUATION

Check each item in proper column.	Normal	Abnormal	Comments
1. Head, Neck, Face, and Scalp			
2. Nose and Sinuses			
3. Mouth and Throat			
4. Teeth and Gingiva			
5. Eyes (lids, conjunctiva)			
6. Pupils and Ocular Motion			
7. Lungs, Chest and Breast			
8. Heart (include estimate of cardiac function)			
9. Vascular System (include varicosities)			
10. Abdomen and Viscera (include hernia)			
11. Ano-rectal and Pilonidal (optional)			
12. Endocrine System			
13. G-U System (optional)			
14. Upper Extremities			
15. Lower Extremities and Feet			
16. Spine; other Musculoskeletal			
17. Skin and Lymphatics			
18. Neurologic			

**To the Health-Care Provider:** After completing the medical history and physical examination, please answer these questions regarding participation in intercollegiate athletic competition.

Cleared for all sports without restrictions     Cleared for all sports with restriction     Not cleared for any sports

Explain \_\_\_\_\_

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Signature of Health-Care Provider \_\_\_\_\_ Date \_\_\_\_\_ Telephone Number (    ) \_\_\_\_\_

Address \_\_\_\_\_

