



Student Health Center
School House Lane & 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. Read all instructions carefully throughout this form.
3. Original Student Health Medical Record must be mailed. Faxes and copies will not be accepted.

PERSONAL IDENTIFICATION

Entering Philadelphia University: _____
Month Year

Program of Study: _____

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

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. Include a copy of both sides of card. Include a copy of an additional card used for prescriptions, if applicable.

[] Student has coverage through family insurance.

Insurance Company Policy Number

Insurance Company Address Group Number

Policy Holder

Insurance Company Phone Number

[] 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

[] 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

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

PHYSICAL EXAMINATION

PART I AND II MUST BE COMPLETE BEFORE RETURNING THIS FORM.

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.

_____ Last Name _____ First Name _____ Middle Name

Blood Pressure _____ Pulse _____ Height _____ Weight _____ lbs. BMI _____ Hearing: Right _____ Left _____

Vision: Right 20/ _____ Corrected to 20/ _____

Left 20/ _____ Corrected to 20/ _____

CLINICAL EVALUATION

Check each item in proper column.	Normal	Abnormal	Comments
1. Head, Neck, Face, or 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 _____

Signature of Health-Care Provider

Date

Telephone Number ()

Address

IMMUNIZATION RECORD

Last Name: _____ First Name: _____ Middle Name: _____

PART II- TO BE COMPLETED AND SIGNED BY HEALTH-CARE PROVIDER.

Varicella 2 doses required without evidence of immunity.	____/____ Mo Yr	____/____ Mo Yr	____/____ Mo Yr	____/____ Mo Yr Quantitative Varicella Antibody validates immunity. (include a copy with this form.)	____/____ Mo Yr physician documented disease
Tetnus-Diphtheria (last dose)	____/____ Mo Yr				
Tetnus-Diphtheria-Pertussis (last dose)	____/____ Mo Yr				
Polio (last dose)	____/____ Mo Yr				
Measels Mumps Rubella 2 doses required without evidence of immunity.	____/____ Mo Yr	____/____ Mo Yr	____/____ Mo Yr	____/____ Mo Yr MMR Titers validate immunity. (include a copy with this form.)	
Meningococcal Tetravalent	____/____ Mo Yr				
Hepatitis B	____/____ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ____	____/____ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ____	____/____ Mo Yr Adult Formulation ____ Child Formulation ____ Combined w/ Hep. A ____	____/____ Mo Yr Hepatitis B Surface Antibody validates immunity. (include a copy with this form.)	
Hepatitis A (recommended)	____/____ Mo Yr	____/____ Mo Yr			
Quadravalent Human Papillomavirus Vaccine (recommended)	____/____ Mo Yr	____/____ Mo Yr	____/____ Mo Yr		

Tuberculin Skin Test (PPD) (Required within 6 months prior to matriculation) The need for this testing will be determined by your physician, and will be made according to your risk factors.

Date given: ____/____/____ Date read: ____/____/____ Result: _____

Chest x-ray (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

Date of chest x-ray: ____/____/____

Signature of Health-Care Provider _____ Date _____ Telephone Number () _____

Address _____