M E M O

To: Parents and Students
From: Sondra Stipcak, BSN, RN, Director Health Services
Townsend Velkoff, MS, Director, Counseling Services
RE: Comprehensive Student Health Record

Welcome to Lycoming College. We hope your years at Lycoming are healthy ones! Enclosed you will find the Comprehensive Student Health Record. This form contains requests for both mandatory and voluntary information. The information provided serves both as a historical health record and notice of pre-existing conditions. Such notice can assist us in notifying you of the services available to you as it relates to your health at Lycoming College.

Student Health Services is open during the academic year Monday through Friday 8:00 am to 4:30 pm and is located in the lower level of Rich Hall. Further information regarding services is available on our website at www.lycoming.edu/healthservices. Counseling Services is open Monday through Friday 8:00 am to 4:30 pm and is located on the third floor of the Wertz Building. The Counseling Center provides crisis intervention, short-term counseling, and referral assistance for all students. Additional information is available on the Counseling website at www.lycoming.edu/counseling.

The enclosed forms are requesting essential information that will enable the College's health providers to deliver the best possible care and assistance to you while at Lycoming College. **Students will not be able to complete the check-in process without submitting a signed Comprehensive Student Health Record.**

Information requested for the Comprehensive Student Health Record is essential for the appropriate treatment of acute conditions, to ensure continuity of care for chronic conditions and to comply with statutes concerning student immunizations. All information contained in the Comprehensive Student Health Record is considered confidential and is not shared with other campus departments without student permission or, in cases in which student welfare is in jeopardy.

Complete each section of the Comprehensive Student Health Record as accurately and thoroughly as possible. The information requested for the Mental Health History is voluntary. In order for the form to be considered complete, **the student's signature must appear on page 2.**

Please pay particular attention to several sections:

Immunizations: All spaces in the immunization portion must be filled in, blank spaces indicate incomplete vaccinations. Family physicians, as well as high school records and baby books, are good places to check for dates of past immunizations. If a student is unable to obtain immunization records, serological titers (blood work) may be sent as proof of vaccinations. Health Services also provides immunizations at a cost.

Health History: Please note any student with a history of asthma and a current prescription inhaler must have a completed Asthma Action Plan. This form can be accessed at www.lycoming.edu/healthservices. Additionally, all diabetic students should review the College's Sharps Disposal Policy which can be accessed at www.lycoming.edu/healthservices.

Mental Health History: Mental health issues can influence adjustment to and academic success in college. This voluntary section is designed to inform Health Services and Counseling Services of both prior or existing mental health issues and treatment.

If you have any questions or concerns, please feel free to contact Student Health Services at 570-321-4052 or Counseling Services at 570-321-4258. Thank you for your cooperation.

LYCOMING COLLEGE
STUDENT HEALTH SERVICES
HEALTH RECORD CHECKLIST

The checklist below is designed to assist parents and students in ensuring all portions of the Comprehensive Student Health Record are completed. Health Records and physicals are only required by Health Services your first year and will be kept on file for seven years after graduation.

☐ I have completed **page 1 & 2** of the **COMPREHENSIVE STUDENT HEALTH RECORD**

☐ I have **signed in <u>two</u> places**: page 1 and page 2

☐ I have enclosed a copy <u>(front and back)</u> of my **INSURANCE CARD**

☐ I have completed the health insurance waiver/enrollment process online

☐ I have taken **page 3 & 4** the **PHYSICAL EXAMINATION & IMMUNIZATION RECORD** to my physician and he/she has done the following:

- ☐ Completed a **physical exam**
- ☐ Completed the TB Risk Assessment and had a PPD placed and read **if I answered "yes" to any of the risk assessment question.**
- ☐ Completed an Asthma Action Plan **<u>if I currently have a prescription inhaler</u>**
- ☐ **Completed dates for ALL REQUIRED vaccinations** – MMR (2 doses), Tetanus (within the last 10 years), Polio, Hepatitis B (3 doses), Meningococcal (2 doses if 1st dose given before age 16), and Varicella/chicken pox (2 doses, unless had the disease)

☐ I have made a **copy of all health forms** for my personal records

HEALTH RECORD DUE DATES:
Fall Semester: July 1 Spring Semester: January 1

Return lower portion <u>only if ordering vaccine</u>

<u>Immunization Reservation Form</u>

Students are highly encouraged to be vaccinated prior to coming to campus. Students who are unable to get a particular immunization through their family doctors are welcome to receive vaccinations at the Health Center for a fee. So we are able to have adequate supplies of vaccine please return this form to the Health Center no later than July 1 for the fall semester and December 1 for the spring semester.

Immunizations:

□ Chicken Pox $120.00	□ Hepatitis B $35.00 ea dose (age 19 or younger) □ Hepatitis B $70.00 (age 20+)
□ MMR $70.00 □ TB Skin Test $ 8.00	□ Meningitis $125.00 □ Tdap $45.00

Student name_____ Date_____

Payment options on check-in day: cash, check, charge to student ID.
Receipts are available for those wishing to submit their own insurance claim forms.

Updated 05/01/2018

LYCOMING COLLEGE
Student Health Services
700 College Place - Campus Box 144, Williamsport, Pennsylvania 17701-5192
Telephone: 570.321.4052 Fax: 570.321.4355 www.lycoming.edu/healthServices

COMPREHENSIVE STUDENT HEALTH RECORD

In order to provide you with the best possible health care while you are a student at Lycoming College, you are required to complete this form prior to arriving on campus to matriculate. You will not be able to complete the check-in process without a complete health record. The Health History is essential for appropriate treatment of acute conditions, to insure continuity of care for chronic conditions, and to comply with statutes concerning student immunizations. All information obtained is regarded as confidential and will be shared with other College personnel only on a need-to-know basis.

HEALTH SERVICES FORM DUE DATES: FALL SEMESTER – JULY 1 SPRING SEMESTER – JANUARY 1

Biographical Data (to be completed by student):

Last Name _____ First_____ Middle _____ M/F_____

Street Address_____City_____ State_____ Zip_____

Date of Birth (mm/dd/yy)_____ Place of Birth_____ Social Security#_____

Citizenship_____ Anticipated year of graduation from Lycoming College _____

Home telephone ( )_____ Student's Cell ( )_____

Emergency Notification (usually parent(s), guardian or spouse):

Name_____ Relationship_____

Daytime telephone ( )_____ Cell ( )_____

Evening telephone ( )_____ Email _____

Would your emergency contacts primary language of communication be English? Yes / No If no, please list their preferred language: _____

Missing Person Notification (who should we contact if you should be reported missing):

☐ Please check box if Missing Person Notification is the same as Emergency Notification, if not, please complete information below:

Name_____ Relationship_____

Daytime telephone ( )_____ Cell ( )_____

Evening telephone ( )_____ Email _____

ALTERNATE CONTACT: Name_____ Relationship_____

Daytime telephone ( )_____ Cell ( )_____

Evening telephone ( )_____ Email _____

Insurance Information:

Please attach a copy (front and back) of your insurance card. Failure to submit insurance information will result in hospital and/or laboratory charges being billed directly to parents/students.

Insurance Card FRONT & BACK Attached

Consent for Treatment:

I hereby grant permission to the nursing and physician staff of Lycoming College Health Services to render any treatment necessary.

_____ _____

Student Signature (required) Date **Parent/guardian signature REQUIRED if student is under 18**

Authorization To Release Medical Information:

I hereby authorize Lycoming College Health Services to release medical information to any licensed physician, hospital, clinic, or other medical personnel for the purpose of diagnosis and treatment. I understand that information will be released only in the event of an emergency or continuation of care. I also authorize Lycoming College Student Health Center to receive medical records from The Williamsport Hospital ER for the purpose of follow up/ongoing care. A photocopy of this authorization shall be considered as effective and valid as the original. It shall remain in effect while enrolled at Lycoming College or written withdrawal of consent is received in the Health Services office.

_____ _____

Student Signature (required) Date **Parent/guardian signature REQUIRED if student is under 18**

Student's Name_____ Date of Birth_____

MENTAL HEALTH HISTORY

If you do not have a mental health history, leave this section blank and sign at the bottom of this page.

All information disclosed in this section will be kept confidential and shared with appropriate College personnel on a need-to-know basis.

	Have you had or experienced any of the following during high school	**Yes**	**No**	**(If yes, explain, add pages if needed)**
1.	Depression	☐	☐	
2.	Anxiety	☐	☐	
3.	Self-harming behavior(s) such as cutting	☐	☐	
4.	Disordered eating	☐	☐	
5.	Bipolar disorder	☐	☐	
6.	Obsessive-compulsive disorder	☐	☐	
7.	Anger management issues	☐	☐	
8.	Attention Problems (ADD, AD/HD)	☐	☐	
9.	Alcohol or substance abuse or dependence	☐	☐	
10.	Other (please specify)_____	☐	☐	
11.	Are you now taking medication for any of the above? (Specify medications) _____	☐	☐	
12.	Do you intend to continue taking medication during college?	☐	☐	
13.	Have you been hospitalized for a psychiatric disorder? If yes, when _____	☐	☐	
14.	Are you currently participating in outpatient psychotherapy?	☐	☐	
15.	Do you intend to continue meeting with your at-home therapist while attending college?	☐	☐	
16.	Are you interested in meeting with someone from Counseling Services?	☐	☐	
17.	Do you want help finding off-campus psychological or psychiatric services?	☐	☐	

I have read and completed all aspects of the Comprehensive Health Record and provided accurate information about my medical and mental health history.

_____ _____

Student Signature Date

Student's Name_____ Date of Birth _____

PHYSICAL EXAMINATION **(Must be completed by a Health Care Provider)**

Temperature	Pulse	Blood Pressure	Height	Weight

Do abnormalities appear in the following systems:

NO	YES		IF YES, PLEASE EXPLAIN
□	□	Head, Ears, Nose and Throat	_____
□	□	Respiratory	_____
□	□	Cardiovascular	_____
□	□	Gastrointestinal	_____
□	□	Eyes	_____
□	□	Genitourinary	_____
□	□	Musculoskeletal	_____
□	□	Metabolic/Endocrine	_____
□	□	Neuropsychiatry	_____
□	□	Skin	_____

Medication Allergies:

_____

_____

Medications (Name and dosage):

_____

□ Asthma with prescription inhaler
******Asthma Action Plan Required**
Required form available at www.lycoming.edu/healthservices
□ Asthma (a past history of asthma with no current medications)

□ Diabetes *****Please see our Sharps Disposal Policy available at** www.lycoming.edu/healthservices

Is this student under treatment for any physical conditions _____

Specific recommendations for care of this student _____

Dietary restrictions _____

TB Risk Assessment
(To be completed by Health Care Provider)

1.	Does the patient have signs or symptoms of active TB?	Yes □ No □
2.	Has the patient had close contact with anyone with infectious TB?	Yes □ No □
3.	Has the patient had contact with anyone recently in jail, has HIV infection or uses IV drugs?	Yes □ No □
4.	Has the patient resided in, been an employee of, or volunteered in a high risk congregate setting (prison, nursing home, hospital, homeless shelter, etc.)	Yes □ No □
5.	Does the patient have a high risk clinical condition (diabetes, HIV infection, silicosis, chronic renal failure, low body weight (10% or more below ideal weight)	Yes □ No □
6.	Is the patient foreign born?	Yes □ No □
7.	Has the patient ever traveled outside the U.S. or Canada?	Yes □ No □
7(a)	If yes, name of country _____	
8.	Other indications?	Yes □ No □
9.	Has the patient ever had a **positive** TB skin test?	Yes □ No □

If Yes: When_____ Date and result of chest x-ray_____

Treatment plan_____

***** A "yes" response to any of the above questions except #9 requires a TB skin test (PPD mantoux only)**

Date test placed_____ Date read_____ Result in mm_____ (Read in 48-72 hours)

A chest x-ray with physician treatment plan is required for positive results.

Date of examination_____ Printed Name of Physician_____

Signature of Physician_____

Street Address_____ City_____State_____ Zip _____

Phone ____ _____ Fax _____

*****IMPORTANT: IMMUNIZATION DATES & PHYSICIAN SIGNATURE REQUIRED ON PAGE 4 OF THIS FORM*****

Student's Name_____ Date of Birth_____

IMMUNIZATION RECORD

Please do not simply attach a copy of the immunization record. Please fill in all dates below. Thank you!

All listed immunizations are required. Failure to maintain up-to-date immunizations will prevent students from attending classes.

(a) MMR#1_____ #2_____ **or** (**M)**easles#1 _____ (M)easles#2 _____

(b) (**M)**umps _____ (M)umps _____

(c) (**R)**ubella _____ (R)ubella _____

(d) Tetanus _____ or (Tdap) _____ Tetanus/Diphtheria/Pertussis (within the last 10 years)

(e) Polio series #1_____ #2_____ #3_____ #4_____

(f) Hepatitis B #1_____ #2_____ #3_____

(g) Varicella (chicken pox) vaccine (2 dose series required) #1_____ #2_____

or approximate year in school or age had the disease _____

(h) MCV4 (Meningococcal) vaccine (2nd dose required if 1st dose is given prior to age 16)

#1_____ #2_____

Printed Name of Physician_____

Signature of Physician_____

Mail or Fax to:

Lycoming College
Student Health Services
700 College Place – Campus Box 144
Williamsport, PA 17701
Fax 570-321-4355

ATTENTION ATHLETES

You must complete this form AND the athletic training form.

ATHLETES ONLY Forms can be found at
http://athletics.lycoming.edu/
Click on the tab Inside Athletics and then Athletic Training Forms

UPDATED 05/21/2018