



OFFICE OF HEALTH SERVICES

York College of PA
York PA 17403-3651

(717) 849-1615

Fax: (717) 849-1601

email: healthcenter@ycp.edu

DEADLINES: Fall: June 30; Spring: January 1

Name _____ DOB ____/____/____
LAST FIRST MI
 Home Address: Street _____ City: _____ State: __ Zip: _____
 Student Cell Phone _____ Home Phone _____
 Name of Parent/Guardian(Emergency Contact) _____ Relationship _____
 Contact Phone Number _____

Insurance Information:

Insurance Company Name _____ Policy Holder _____
 Policy or ID # _____ Group # _____

Preferred lab for your insurance: _____

PLEASE ENCLOSE A COPY OF *FRONT* AND *BACK* OF INSURANCE CARD.

PERMISSION FOR TREATMENT

I hereby grant permission to York College, or its authorized providers, which may include student nurses, nurse practitioner students, physician assistant students, medical students, residents, as well as nurse practitioners and physicians, to furnish such medical care as my son/daughter/self may require, including examination, treatment, immunizations, etc. This permission is conditioned upon the understanding that in the event of serious illness or the need for hospitalization and/or major surgery, the College will use all reasonable efforts to contact my emergency contact. Failure in such efforts, however, should not prevent the College from providing such emergency treatment and exchange of records as may be necessary by an off-site provider.

We ask that the student verify with their parents, and/or with their insurance company, participating hospitals, laboratories, and physicians in the York College area in case treatment and/or service are needed outside of YCP Health Services.

If this information is not known at the time of visit or unable to be obtained, we will send the student to the nearest facility located to YCP.

In the event that payment for services by an outside provider is denied by your insurance company, we ask that the student or guarantor accept financial responsibility and not hold YCP Health Services responsible for expenses incurred under these conditions.

Having read the above statements signifies that I understand the contents and agree to be responsible for this information and any expenses incurred.

Signature _____ Date ____/____/____

NOTE: Parent or legal guardian must sign if the student is under 18 years of age.
 Religious Preference (optional) _____

MEDICAL HISTORY

PLEASE COMPLETE THIS BEFORE GOING TO YOUR HEALTHCARE PROVIDER FOR EXAMINATION

1. List any illness or medical condition for which you are being treated currently.

Condition Year Diagnosed Treatment

2. List any operations or hospitalizations you have had.

3. List all medications you are now taking (including over-the-counter, supplements, birth control pills, allergy serum, psychotropics)

Name of Medication Dose How Often

4. List your **ALLERGIES** to: _____ Reaction: _____

Medications: _____

Environment/Food/Insects: _____

MEDICAL HISTORY: Check all applicable items, whether current or past. Give details in the space provided below.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Congenital defects | <input type="checkbox"/> Heart defects | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Orthopedic infections | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Treatment by |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Diabetes mellitus | psychologist, psychiatrist, |
| <input type="checkbox"/> Hearing defects | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Endocrine problem | or counselor |
| <input type="checkbox"/> Serious eye defects | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Smoker | <input type="checkbox"/> Menstrual disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Drug problem | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic disorder | <input type="checkbox"/> Alcohol problem | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Learning disability/ADD | <input type="checkbox"/> Concussion |
| | | | <input type="checkbox"/> Other |

Please provide details of above items checked:

FAMILY HISTORY

Have any of your relatives had any of the following:

	Yes	No	Relationship
Cancer			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Kidney Disease			
Lung Disease			
Tuberculosis			
Ulcer Disease			

PHYSICAL EXAMINATION

(NCAA ATHLETES: No sooner than April 15)

Date of Exam: _____

Height _____ Weight _____ lbs. BP _____ / _____ Pulse _____

	Normal	Abnormal	Comments
Eyes/Vision			
HEENT/Hearing			
Chest/Lungs			
Heart/Murmur			
Abd/GU/Gyn			
Extremities/Neuro			
Skin/Lymphatic			
Emotional/Psychiatric			

Do you advise any restriction in the following? If so, please explain below under remarks.

	No	Yes
Physical Education	_____	_____
NCAA Athletics (*See below)	_____	_____
Intramural Athletics	_____	_____

Remarks and Recommendations of Provider:

Please note any condition, emotional or physical, plus medications that we should be aware of for continuity of care purposes.

***REQUIRED for participation in NCAA Athletics:**

Sickle cell trait testing results (please research birth screening results) must be obtained and submitted to YCP Health Services.

Please check one: Sickle cell trait (+) _____ Sickle cell trait (-) _____

Provider Signature: _____ MD/DO/CRNP/PA

Printed Name _____

Date: _____

Address _____

Phone Number: _____

Fax Number: _____

IMMUNIZATION RECORD

REQUIRED IMMUNIZATIONS OF ALL YORK COLLEGE STUDENTS:

Tetanus/Diphtheria/Pertussis (within the last ten years).....____/____/____

The following vaccines require official proof of vaccine (medical documentation) OR blood test showing immunity.

Measles, Mumps, Rubella (MMR) – 2 verified doses or titers demonstrating immunity.

Dose 1 given at age 12 months or later #1 ____/____/____

Dose 2 given at least 28 days after dose 1 #2 ____/____/____

OR . . . Blood test confirming immunity (attach copy of lab results)

Varicella (Chicken Pox) – 2 verified doses or titers demonstrating immunity.

#1 ____/____/____ #2 ____/____/____

OR . . . Blood test confirming immunity (attach copy of lab results)

Hepatitis B – 3 dose vaccine or titers demonstrating immunity

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____

OR . . . Blood test confirming immunity (attach copy of lab results)

Meningococcal – quadrivalent vaccine – 2 doses if first dose was given prior to age 16 – 1 dose if given after age 16

#1 ____/____/____ #2 ____/____/____

NOTE: Please read meningitis information on the Centers for Disease Control website under <https://www.cdc.gov/vaccines/hcp/vis/vis-statements/mening.html>.

WAIVER: I have read and understand the information you provided about the risks of meningococcal disease and the availability and effectiveness of the vaccine, but for religious or other reasons, I decline the meningococcal vaccine at this time.

Signature (student) _____ Date _____

Parent (if student under age 18) _____ Date _____

Highly recommended vaccines (please provide documentation of any vaccines that you have received)

Hepatitis A Vaccine – 2 doses #1 ____/____/____ #2 ____/____/____

Human Papillomavirus Vaccine #1 ____/____/____ #2 ____/____/____ #3 ____/____/____

Meningitis B Vaccine #1 ____/____/____ #2 ____/____/____ #3 ____/____/____/ (if Trumenba)

Provider Signature: _____ MD/DO/CRNP/PA

Part I. Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? Yes NoWere you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) Yes No

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Singapore
Algeria	Côte d'Ivoire	Iraq	Nauru	Solomon Islands
Angola	Democratic People's Republic of	Kazakhstan	Nepal	Somalia South Africa
Anguilla	Korea	Kenya	Nicaragua	South Sudan
Argentina	Democratic Republic of the	Kiribati	Niger	Sri Lanka
Armenia	Congo	Kuwait	Nigeria	Sudan
Azerbaijan	Djibouti	Kyrgyzstan	Northern Mariana	Suriname
Bangladesh	Dominican Republic	Lao People's Democratic	Islands	Swaziland
		Republic		
Belarus	Ecuador	Latvia	Pakistan	Tajikistan
Belize	El Salvador	Lesotho	Palau	Thailand
Benin	Equatorial Guinea	Liberia	Panama	Timor-Leste
Bhutan	Eritrea	Libya	Papua New Guinea	Togo
Bolivia (Plurinational State of)	Estonia	Lithuania	Paraguay	Trinidad and Tobago
Bosnia and Herzegovina	Ethiopia	Madagascar	Peru	Tunisia
Botswana	Fiji	Malawi	Philippines	Turkmenistan
Brazil	French Polynesia	Malaysia	Poland	Tuvalu
Brunei Darussalam	Gabon	Maldives	Portugal	Uganda
Bulgaria	Gambia	Mali	Qatar	Ukraine
Burkina Faso	Georgia	Marshall Islands	Republic of Korea	United Republic of
Burundi	Ghana	Mauritania	Republic of Moldova	Tanzania
Cabo Verde	Greenland	Mauritius	Romania	Uruguay
Cambodia	Guam	Mexico	Russian Federation	Uzbekistan
Cameroon	Guatemala	Micronesia (Federated States	Rwanda	Vanuatu
Central African Republic	Guinea	of)	Saint Vincent and the	Venezuela (Bolivarian
Chad	Guinea-Bissau	Mongolia	Grenadines	Republic of)
China	Guyana	Montenegro	Sao Tome and Principe	Viet Nam
China, Hong Kong SAR	Haiti	Morocco	Senegal	Yemen
China, Macao SAR	Honduras	Mozambique	Serbia	Zambia
Colombia	India	Myanmar	Seychelles	Zimbabwe
Comoros	Indonesia		Sierra Leone	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to <http://www.who.int/tb/country/en/>.

Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) Yes NoHave you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)? Yes NoHave you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? Yes NoHave you ever been a member of any of the following groups that may have an increased incidence of latent *M. tuberculosis* infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol? Yes No

If the answer is YES to any of the above questions, York College of Pennsylvania requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

If the answer to all of the above questions is NO, no further testing or further action is required.

* The significance of the travel exposure should be discussed with a health care provider and evaluated.

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to **any** of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) **or** Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes _____ No _____

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes _____ No _____

Tuberculin Skin Test : Date placed _____ **Date read** _____ **Results** _____ **mm**

**Interpretation: positive _____ negative _____

OR Quanti-FERON Test: Results: Positive () Negative ()

****Interpretation guidelines****>5 mm is positive:**

- Recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunioileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

Chest x-ray (required if current or previous TST or QFT test is positive):

Date _____ Normal () Abnormal ()

INH Treatment: Initiate Date _____ **X** _____ **months Declined ()**

Provider Signature: _____ **MD/DO/CRNP/PA**