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 admit: June 15; Spring admit: November 15

Date of Entrance: (circle one) Fall Spring 20____

Name____ DOB _____/_____/_____
LAST FIRST MI

Gender ☐ M ☐ F ☐ T Social Security #_________________________ YCP ID # ____ - ____ - ____

Home Address: Street____ City:________________ State:___Zip:_______

Student Cell Phone___________________________

Name of Parent/Guardian(Emergency Contact)_____________________________ Relationship________________

Home Phone _______________________Work Phone_____________________Mobile Phone__________________

Insurance Information: All students are required to have health insurance

Insurance Company Name________________________ Policy Holder_________________________________

Policy or ID #___________________________________ Group # _____________________________________

Prescription Plan ☐ Y ☐ N

Circle the laboratory covered by your insurance carrier: LabCorp Quest WellSpan

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, 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.

____Congenital defects
____Frequent sore throats
____Sinusitis
____Frequent ear infections
____Hearing defects
____Serious eye defects
____Bronchitis
____Asthma
____Pneumonia
____Heart defects
____Rheumatic fever
____Irritable bowel syndrome
____Ulcer disease
____Inflammatory bowel disease
____Seizure disorder
____Fainting
____Neurologic disorder
____Headaches
____Arthritis
____Orthopedic infections
____Urinary tract infections
____Diabetes mellitus
____Endocrine problem
____Smoker
____Drug problem
____Alcohol problem
____Learning disability/ADD
____Mononucleosis
____Chickenpox
____Treatment by psychologist, psychiatrist, or counselor
____Menstrual disorder
____Skin disorder
____Eating disorder
____Concussion
____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			

____ YCP ID: _____ - _____ - ______

Student’s last name First name MI

Revised 2017-09-01

PHYSICAL EXAMINATION

(Within 6 months of entrance for athletes)

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 toYCP 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:_____________________________

____ YCP ID: _____ - _____ - ______

Student's last name First name MI

IMMUNIZATION RECORD

To Be Completed by Physician/NP/PA:___________________________*(provider signature)*

1. **MMR #1** Date: ____/____/____ **MMR #2** Date:____/____/____ (Dose 1 at 12 months or after, dose 2 at least 28 days after dose 1)
   Or, Rubeola Titer: ☐POS ☐NEG ***Rubella Titer***: ☐POS ☐NEG ***Mumps Titer***: ☐POS ☐NEG
   Date of Titer:____/____/____ Date of Titer:____/____/____ Date of Titer: ____/____/____

2. **Varicella (Chicken pox) Date of Disease: ___/___/___ ,** ***OR***
   Immunization: **Two Doses Required: DOSE #1** Date: ____/____/____ **DOSE #2** Date: ____/____/____ , ***OR***
   Varicella titer: ☐POS ☐NEG
   Date of titer: ____/____/____

3. **Tdap required** Date: ____/____/____**(within the last 10 years)**

4. **Hepatitis B: (3 doses required)**
   Dose #1: Date: ___/___/___ **DOSE #2** Date: ___/___/___ **DOSE #3** Date: ___/___/___
   Or, Result of Hepatitis B Surface Antibody titer: ☐ POS ☐NEG Date of titer:___/___/___

--**ATTENTION PROVIDERS**------------------------------------

5. **Tuberculin Skin Test** ***REQUIRED***
   (*Dates older than one (1) year will NOT be accepted.)*
   Date Applied:___/___/___ Date Read*: ___/___/___ Results in millimeters: _________

   If results 10 millimeters or greater, attach copy of chest x-ray report.
   Please note if patient referred to local health department for treatment/follow-up: ☐ Yes ☐No

   **** Must be within 48-72 hours or test considered invalid.***

6. **This section MUST BE COMPLETED BY ALL STUDENTS:**

MENINGITIS Immunization Information		Waiver:
Date of most recent immunization: ________________________________ ♦(Refer to enclosed Meningitis fact sheet)	**OR**	I have received and reviewed the enclosed information regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I knowingly decline to receive the vaccine at this time. ______________________________ __________ **Signature of Student** **Date**

____ YCP ID: _____ - _____ - ______
Student's last name First name MI

Revised 2017-09-01