CARLOW
UNIVERSITY

MAIL TO:
Carlow University Health Services
3333 Fifth Avenue
Pittsburgh, Pennsylvania 15213
(Return envelope enclosed for your convenience.)

DIRECTOR:
Carla Bergamasco, MSN, RN
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LOCATION:
4th Floor, Frances Warde Hall

HEALTH HISTORY
IMMUNIZATION DOCUMENTATION FORM

Carlow University requires all incoming, full-time, traditional-age students (first-year and transfer) to complete and return a Health History/Immunization Documentation Form. The immunization portion must be signed by a health care provider. The entire form must be completed and submitted prior to the first day of class. Resident students will not be permitted to move into the resident halls if this form has not been submitted. Student athletes are required to complete and submit both this form as well as the health forms that they receive from the Department of Athletics .

CONFIDENTIALITY

The information on this form will be used, if necessary, solely as an aid to provide health care while you are a student at Carlow University. Except in emergencies, or when required by law, no medical information will be given to parents or guardians without the written or oral permission of the student. No medical information will be shared with Carlow professors or staff without the written consent of the student. Medical information will be released to other health professionals, potential employers, insurance companies, etc. only with the written consent of the student.

ACCOMMODATIONS

Students who require special accommodations should contact Jackie Smith in the Office of Disabilities Services at 412.578.6257.

CONSENT FOR CARE

I, _____, voluntarily give my consent to Carlow University Health Services, and such medical provider and/or assistant to the Carlow University Health Services as they may deem necessary to provide medical services to me. I am authorizing Carlow University Health Services to treat me during my enrollment as a Carlow University student or until I withdraw my consent in writing.

I understand that there is no fee to see the nurse, but there is a $10 fee to see the physician that will be billed directly to my student account, and I am financially responsible for that fee. I also understand that I am financially responsible for all charges incurred for any and all services received outside of Carlow University Health Services, including ambulance fees, lab fees, etc., if necessary.

I hereby certify that I have read fully the above authorization and that no guarantee has been made as to the results that may be obtained from the provision of a medical service.

By submission of this Health History Immunization Documentation form, I am attesting to the fact that the above information pertains to my personal health history and is true and correct.

Signature _____ Date _____

Parent or guardian signature (if student under 18 yr.) _____ Date _____

Please check: ○ Resident ○ Commuter Start term: ○ Fall ○ Spring ○ Summer Year _____

TO BE COMPLETED BY STUDENT

STUDENT'S LAST NAME	FIRST NAME	MIDDLE
ADDRESS WHILE ATTENDING THE UNIVERSITY (NO. AND STREET)		
PHONE WHILE ATTENDING THE UNIVERSITY (AREA CODE AND NO.)	BIRTH DATE (MO/DAY/YR)	MARITAL STATUS ○ Single ○ Married
SEX ○ Male ○ Female ○ FTM ○ MTF		

PERMANENT MAILING ADDRESS (NO. AND STREET)	CITY	ST ATE	ZIP CODE	PHONE (AREA CODE AND NO.)
PERSON TO BE NOTIFIED IN AN EMERGENCY	Last name	First name	Middle	RELATIONSHIP
ADDRESS (IF DIFFERENT FROM PERMANENT ADDRESS)				PHONE (AREA CODE AND NO.)
NAME OF FAMILY OR PERSONAL PHYSICIAN				PHONE (AREA CODE AND NO.)
ADDRESS (NO. AND STREET)	CITY		STATE	ZIP CODE

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS					
SISTERS					

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS.

Y	N	Have you had?
○	○	Mononucleosis
○	○	Hepatitis
○	○	Chickenpox
○	○	Gum or Tooth Trouble
○	○	Sinusitis
○	○	Eye Trouble
○	○	Ear Problem
○	○	Nose Problem
○	○	Throat Problem
○	○	Diabetes
○	○	Convulsions
○	○	Eczema
○	○	Head Injury with Unconsciousness
○	○	Neck Injury
○	○	Thyroid
○	○	Insomnia

Y	N	Have you had?
○	○	Frequent Anxiety
○	○	Frequent Depression
○	○	Frequent Headaches
○	○	Worry or Nervousness
○	○	Hayfever
○	○	Bronchitis
○	○	Pneumonia
○	○	T.B.
○	○	Shortness of Breath
○	○	Asthma
○	○	Chest Pain
○	○	Chronic Cough
○	○	Back Problems
○	○	Disease or Injury of Joints
○	○	Hearing Difficulty
○	○	Palpitations (Heart)

Y	N	Have you had?
○	○	High BP
○	○	Low BP
○	○	Rheumatic Fever
○	○	Heart Murmur
○	○	Tumor, Cancer, Cyst
○	○	Jaundice
○	○	Gall Bladder Trouble
○	○	Intestinal Trouble
○	○	Stomach Trouble
○	○	Recent Weight Gain
○	○	Recent Weight Loss
○	○	Eating Disorder
○	○	Weakness, Paralysis
○	○	Dizziness or Fainting
○	○	Kidney Infection
○	○	Recurrent Diarrhea

Y	N	Have you had?
○	○	Recurrent Constipation
○	○	Rupture, Hernia
○	○	Environmental allergies
○	○	Substance abuse
○	○	Sexually Transmitted Disease

FEMALES ONLY

Y	N	Have you had?
○	○	Irregular Periods
○	○	Severe Cramps
○	○	Excessive Flow

IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE ABOVE CONDITIONS, PLEASE CIRCLE THE CONDITION ON THE ABOVE CHART.

NAME _____ BIRTHDATE _____

1. Please list any allergies and the reaction you experienced when exposed to that agent.

   Agent _____ Reaction _____
   Agent _____ Reaction _____
   Agent _____ Reaction _____

2. Please list any medications you are currently taking.

   _____

3. Do you have a history of or are you currently receiving treatment for a mental health condition such as anxiety, depression, or other?

   Please explain _____

   Carlow University Counseling Services provides free intake assessments and short-term individual counseling, brief psychotherapy sessions, and psychiatric assessments and consultations. Counseling Services also provides external referrals for students in need of long-term treatment, specialized care, or medication management. Students currently involved in treatment with an external mental health professional are strongly encouraged to remain in treatment or to obtain comparable treatment locally in order to maintain continuity of care. Please contact Counseling Services at 412.578.8731 or 412.578.6303) in advance of your arrival to campus so that we can discuss how best to meet your needs.

4. Please list any dietary or activity restrictions. _____

5. Do you use tobacco products? Yes ____ No ____ How long? _____ How much? _____

6. Do you use alcohol? Yes ____ No ____ How long? _____ How much? _____

7. Do you use recreational drugs? Yes ____ No ____ How long? _____ How much? _____

8. Have you ever been, or are you currently in an abusive relationship or situation, or are you in danger of being in one?

   Yes ____ No ____ Please explain _____

9. Please list surgeries or hospitalizations you have had for treatment of any illnesses or conditions, and give the date.

   Reason _____ Date _____
   Reason _____ Date _____
   Reason _____ Date _____

10. Is there any additional information, or do you have any concerns regarding your physical, emotional, psychological, social, or spiritual well-being?

    _____

IMMUNIZATION RECORD (TO BE COMPLETED BY HEALTH CARE PROVIDER OR ATTACH COPY OF RECORD FROM HEALTH CARE PROVIDER)

		Date	Date	Date
REQUIRED VACCINATIONS FOR ALL INCOMING TRADITIONAL-AGE STUDENTS (FIRST-YEAR AND TRANSFER)	Measles, Mumps, Rubella (MMR) * Please note two dose requirement if born after 1957.			
ADDITIONAL REQUIREMENTS FOR RESIDENCE HALL STUDENTS	Meningococcal Vaccine (required by Pennsylvania law for students living on campus)			
	Hepatits B series (three doses)			
RECOMMENDED VACCINATIONS FOR ALL STUDENTS	Varicella (chickenpox) or date of disease			
	Tetnus, Diptheria, Pertussis (Tetanus Booster within last 10 years)			
	Polio (OPV, IPV)			
	Hepatitis A vaccine			
	Influenza (especially nursing and education majors)			
	HPV (Human Papillomavirus, females 13-26) three doses			
	Other			
ADDITIONAL REQUIREMENTS FOR INTERNATIONAL STUDENTS	Tuberculin Skin Test (PPD) within 1 year of enrollment			
	Chest X-ray (required if skin test is positive)			

HEALTH CARE PROVIDER COMPLETING IMMUNIZATION RECORD:

Name _____ Telephone number _____

Signature _____ Date _____

WHY VACCINATE?

Measles
Measles is a highly contagious virus that can be spread by coming into contact with an infected person or the infected person's saliva through coughing and sneezing. It can cause serious illness such as pneumonia and encephalitis (inflammation of the brain). Two doses of vaccine provide lifelong protection. The vaccine can be administered alone or as part of the combination Measles, Mumps, Rubella (MMR) shot.

Mumps
Mumps is mainly a disease of younger children, but about 15 percent of reported cases occur among teens and adults. Mumps an cause deafness, encephalitis, meningitis, and rarely, sterility. Mumps vaccine can be administered as part of the MMR shot.

Rubella
Rubella (German measles) is caused by a virus that is spread by contact with infected people or articles that have been used. Symptoms can include rash, muscle pain, low-grade fever, and swelling in the neck. Rubella is especially dangerous for the fetus during the first three months of pregnancy. The pregnant woman may miscarry or the baby may be born with birth defects. Rubella is routinely administered as part of the MMR shot or may be given as a single-component vaccine.

Hepatitis B
Hepatitis B is a serious liver disease caused by a virus. The virus can be spread by coming into contact with the blood or other bodily fluids of an infected person. Hepatitis B virus can cause inflammation of the liver, which can lead to serious illness, liver cancer, and liver failure. Immunity is achieved by receiving a series of three injections of vaccine over a six-month period.

Meningitis
Although meningitis is rare, it is potentially fatal when it strikes. Meningococcal meningitis is a bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord. The infection can lead to permanent disabilities, such as hearing loss and brain damage. College students living in residence halls are at increased risk for developing the infection. Meningococcal bacteria are transmitted through air droplets and direct contact with persons already infected with the disease. This can be through coughing, kissing, sneezing, or sharing items like utensils, cigarettes, or drinking glasses. Symptoms of Meningococcal meningitis often resemble those of the flu. These symptoms include high fever, rash, vomiting, severe headache, neck stiffness, lethargy, nausea, and sensitivity to light. Pennsylvania State Law requires this vaccine for all college/university students residing on campus.

Tdap (Adacel)
Pertussis has become more prevalent in the U.S. over the last 20 years, especially among adolescents and adults. Pertussis can be spread easily which makes the infection difficult to control once it is established in the community. The use of antibiotics does not significantly alter the course of infection once you acquire the cough related to Pertussis. One-time use of Tdap is recommended for adults between the ages of 19 and 64.

For more information on immunizations, please visit: www.immunize.org or www.cdc.gov/ncidod/dbmd/diseaseinfo .

MEDICAL EXEMPTION (CHECK ALL THAT APPLY)

I have been advised by my physician that I should not receive vaccination for: ○ Measles ○ Mumps ○ Rubella ○ Hepatitis B ○ Meningitis

Due to the following condition: _____

I understand that I am subject to exclusion from Carlow University's campus in the event of a disease for which I am not vaccinated.
I have read and understand the information about these diseases and the risks involved.

Name of physician: _____ Office telephone number: _____

RELIGIOUS EXEMPTION

I affirm that immunization is in conflict with my religious beliefs. I understand the risks and am choosing not to be vaccinated at this time. I understand that I am subject to exclusion from Carlow University's campus in the event of an outbreak of any of the above diseases for which I am not vaccinated.

_____ _____ _____

SIGNATURE OF STUDENT SIGNATURE OF PASTOR DATE