LYCOMING COLLEGE

STUDENT HEALTH SERVICES
700 COLLEGE PLACE
WILLIAMSPORT, PA 17701-5192
PHONE: 570-321-4322 FAX 570-321-4355

PART TIME STUDENT HEALTH RECORD

Biographical Data (to be completed by student)

Last Name _____ First_____ Middle _____ M/F_____

Street Address_____

City_____ State_____ ZIP_____ Date of Birth_____

Place of Birth_____ Social Security#_____

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

Citizenship_____

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

Name_____ Relationship_____

Home telephone ( )_____ Cell ( )_____

Business phone ( )_____

Health History

1. List any medication allergies:_____
2. List all current medication you are taking:_____
3. Have you past or present had any of the following conditions:

_____ Heart Disease	_____ High blood pressure
_____ Diabetes	_____ Gastrointestinal disorders
_____ Seizures	_____ Musculoskeletal disorders
_____ Asthma	_____ Environmental allergies
_____ Emotional difficulties	

4. Are you currently under treatment for any ongoing medical problems?_____

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 ONLY 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 ONLY if student is under 18

PHYSICAL EXAM

(To be completed by Health Care Provider)

***a copy of a recent physical within the last 3 years may be substituted**

Student Name_____ Date of exam_____
Vital signs: B/P_____ HR_____ Height_____ Weight_____

EENT	Normal/Adnormal	Explain_____
Mouth/Teeth	Normal/Abnormal	Explain_____
Cardiovascular	Normal/Abnormal	Explain_____
Pulmonary	Normal/Abnormal	Explain_____
Gastrointestinal	Normal/Abnormal	Explain_____
Genitourinary	Normal/Abnormal	Explain_____
Integument	Normal/Abnormal	Explain_____
Lymphatic	Normal/Abnormal	Explain_____
Musculoskeletal	Normal/Abnormal	Explain_____
Neurological	Normal/Abnormal	Explain_____
Psychosocial	Normal/Abnormal	Explain_____

Any pertinent past medical history:

Additional Comments:

_____Print Physician Name

_____Physician Signature

_____Physician Phone

Immunizations

1. MMR#1_____ #2_____ **or** (**M)**easles#1 _____ (M)easles#2_____
   (**M)**umps _____ (M)umps _____
   (**R)**ubella _____ (R)ubella _____
   *required for all individuals born **after** 1956

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

3. Varicella (chicken pox) vaccine is a (2 dose series) #1_____ #2_____
   or approximate year or age of disease _____

****Students going on to become full-time students will be required to provide documentation for the following vaccines. These vaccines are highly recommended for our part-time students but not required.**

4. Hepatitis B #1_____ #2_____ #3_____

5. Meningococcal vaccine #1 _____ #2_____ (2nd dose required if 1st dose is given prior to age 16)
   *PA state law requirement of all students living in campus housing.

6. TB Risk Assessment Form (Available at Student Health Services)