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.
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 two places: page 1 and page 2

☐ I have enclosed a copy (front and back) of my INSURANCE CARD

☐ I have completed the health insurance waiver/enrollment process online at www.firststudent.com

☐ 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 if I currently have a prescription inhaler

☐ 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 only if ordering vaccine

Immunization Reservation Form

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:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicken Pox</td>
<td>$110.00</td>
</tr>
<tr>
<td>MMR</td>
<td>$60.00</td>
</tr>
<tr>
<td>TB Skin Test</td>
<td>$7.00</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>$35.00 ea dose</td>
</tr>
<tr>
<td></td>
<td>(age 19 or younger)</td>
</tr>
<tr>
<td>Meningitis</td>
<td>$125.00</td>
</tr>
<tr>
<td>Tdap</td>
<td>$45.00</td>
</tr>
</tbody>
</table>

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 03/06/2017
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.

*Health insurance is required for all students. Each student must complete the online waiver/or enroll in the college plan at www.firststudent.com at the start of each school year.

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

PAGE 1
# 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.

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

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

<table>
<thead>
<tr>
<th>Temperature</th>
<th>Pulse</th>
<th>Blood Pressure</th>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

Do abnormalities appear in the following systems:

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>
| □ | □  | Head, Ears, Nose and Throat
| □ | □  | Respiratory
| □ | □  | Cardiovascular
| □ | □  | Gastrointestinal
| □ | □  | Eyes
| □ | □  | Genitourinary
| □ | □  | Musculoskeletal
| □ | □  | Metabolic/Endocrine
| □ | □  | Neuropsychiatry

IF YES, PLEASE EXPLAIN

**Medication Allergies:**

- □ Asthma with prescription inhaler
- ****Asthma Action Plan Required
  Required form available at [www.lycoming.edu/healthservices](http://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](http://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***

PAGE 3
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__________________________________________________________

ATTENTION ATHLETES
You must complete this form AND the athletic training form.
Contact the athletic department for more information.

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

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