LYCOMING COLLEGE

Student Health Services

ONE COLLEGE PLACE • BOX 144
WILLIAMSPORT, PA 17701-5192
P: 570.321.4052 F: 570.321.4355
EMAIL: health@lycoming.edu

Rich Hall (garden level) hours during the academic year:
Monday - Friday
8:00 A.M. – 4:30 P.M.

COMPREHENSIVE NEW STUDENT
HEALTH FORM

This form must be completed and returned no later than July 1 for fall enrollment to:

MAIL TO:

Lycoming College
Student Health Services
One College Place • Box 144
Williamsport, PA 17701

FAX TO:

570-321-4355

During the months of **June and July**, inquiries regarding the health form are received Monday & Tuesday only 8:00 a.m. – 2:00 p.m. at 570-321-4052

WELCOME TO LYCOMING COLLEGE.

We hope your years at Lycoming are healthy ones.

Information requested on the **Comprehensive Student Health Form** 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 health form is considered confidential and is not shared with other campus departments without student permission or, in cases in which student welfare is in jeopardy.

Mental health issues can influence adjustment to and academic success in college. The Mental Health History is a voluntary section designed to inform Health Services and Counseling Services of both prior or existing mental health issues and treatment.

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CHECKLIST/DIRECTIONS FOR PREPARING AND RETURNING THE LYCOMING COLLEGE NEW STUDENT HEALTH FORM

- ◯ I have completed **page 1 & 2** of the Comprehensive New Student Health Form and signed pages 1 & 2.
- ◯ I have enclosed a copy of my **health insurance card** (front and back)
- ◯ I have completed the **health insurance waiver/enrollment** process online.
- ◯ I have **scheduled an appointment with my family doctor** to complete the physical examination and immunization portion of the health form
- ◯ I have taken page 3, 4 & 5 to my physician and he/she has completed the **physical examination** portion and all required **immunizations** have been documented on page 5
- ◯ If I currently use a prescription inhaler, I have had the prescribing physician complete the **Asthma Action Plan** form and included it with my health form. Form can be found at www.lycoming.edu/healthservices
- ◯ If I answered 'yes' to any of the **TB Risk Assessment** questions on my health form, I have had a TB test done and my physician has documented the results and treatment on the health form. If a chest x-ray was ordered, I have included a copy of the lab report with my health form.
- ◯ If I do not have all of the required immunizations, I have scheduled an appointment with my family doctor to receive missing vaccines.
- ◯ I have completed the Patient HIPAA Communication Form
- ◯ **I have made a copy of my health form for my personal records.**
- ◯ I have **mailed or faxed my health form** to Student Health Services by July 1st for the fall semester or January 1st for the spring semester. **HEALTH FORMS ARE ONLY REQUIRED IN OUR OFFICE YOUR FIRST SEMESTER ON CAMPUS**

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Student Health Services
One College Place • Box 144
Williamsport, PA 17701

FAX TO:

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Any questions or concerns regarding the health form, please call 570-321-4052

LYCOMING COLLEGE

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COMPREHENSIVE STUDENT HEALTH RECORD

ONE COLLEGE PLACE | BOX 144 | WILLIAMSPORT, PA 17701-5192 | P: 570.321.4052 | F: 570.321.4355 | EMAIL: health@lycoming.edu

DEMOGRAPHICS — TO BE COMPLETED BY STUDENT

Legal Name _____
LAST FIRST MIDDLE

Preferred Name _____

Home Address _____

City _____ State _____ Zip _____

Home Telephone ( ) _____

Student Cell ( ) _____

Citizenship _____

Anticipated Graduation Year _____

Date of Birth _____

Place of Birth _____

Sex Assignment at Birth M/F _____

Gender Identity _____

Preferred Pronoun _____

EMERGENCY NOTIFICATION

Name _____ Relationship _____ Cell # ( ) _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Would your emergency contacts primary language of communication be English? ◯ Yes ◯ No If no, please list preferred language _____

MISSING PERSON NOTIFICATION

◯ Check if missing person notification is the same as emergency notification. If not, please complete.

Name _____ Relationship _____ Cell # ( ) _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Would your emergency contacts primary language of communication be English? ◯ Yes ◯ No If no, please list preferred language _____

ALTERNATE CONTACT:

Name _____ Relationship _____ Cell # ( ) _____

Daytime Phone ( ) _____ Evening Phone ( ) _____

Would your emergency contacts primary language of communication be English? ◯ Yes ◯ No If no, please list preferred language _____

INSURANCE INFORMATION

◯ Attach a copy of your health insurance card (front and back). **IF YOU DO NOT HAVE INSURANCE OR YOUR INSURANCE PLAN DOES NOT MEET OUR WAIVER REQUIREMENTS, YOU MUST ENROLL IN THE COLLEGE HEALTH PLAN**

CONSENT FOR TREATMENT

I hereby grant permission to the nursing and physician staff at Lycoming College Student Health Services to render any treatment necessary.

X _____ Student Signature (required) Date

X _____ Parent/Guardian Signature (required if student is under the age of 18) Date

I hereby authorize Lycoming College Student 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 Services to receive medical records from UPMC Emergency Department for the purpose of follow-up/on-going 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 Student Health Services office.

X _____ Student Signature (required) Date

X _____ Parent/Guardian Signature (required if student is under the age of 18) Date

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MENTAL HEALTH HISTORY — TO BE COMPLETED BY STUDENT

Student Name: _____ Date of Birth _____
LAST FIRST MIDDLE

IF YOU DO NOT HAVE A MENTAL HEALTH HISTORY, LEAVE THIS SECTION BLANK AND SIGN AT THE BOTTOM OF THIS PAGE ONLY

All information disclosed in this section will be kept confidential and shared with appropriate college personnel on a need-to-know basis.

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

I have read and completed all aspects of the Comprehensive Health Record and provided accurate information about my medical and mental health history.

X _____ _____
Student Signature (required) Date

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TB RISK ASSESSMENT — TO BE COMPLETED BY A HEALTH CARE PROVIDER

Student Name: _____ Date of Birth _____
LAST FIRST MIDDLE

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. Was patient born outside the United States or Canada? 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 _____ (x-ray report attached)

   Treatment plan _____

A "YES" RESPONSE TO ANY OF THE ABOVE QUESTIONS EXCEPT #9 REQUIRES A TB SKIN TEST

TEST PLACED

◯ TB Fact Sheet given ◯ Pre-Test Questions Reviewed

Date Test Placed: _____

Site: ◯ Right Forearm ◯ Left Forearm

Lot # _____ Exp Date _____

Manufacturer: _____

Signature of Provider Testing:

_____

Additional Comments:

TEST READ

Date Test Placed: _____
(within 48-72 hours from date placed)

Induration: _____ MM

Interpretation: ◯ Negative ◯ Positive

Read by: _____

Additional Comments:

A chest x-ray with physician treatment plan is required for positive results.

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Student Name: _____ Date of Birth_____
LAST FIRST MIDDLE

PHYSICAL EXAMINATION — TO BE COMPLETED BY A HEALTH CARE PROVIDER

Temperature _____ Pulse _____ Blood Pressure _____ Height _____ Weight _____

Current prescription and nonprescription medication(s) with dosage(s): ◯ No ◯ Yes, please list: _____

_____

Medication Allergies: ◯ No ◯ Yes _____
Food Allergies: ◯ No ◯ Yes _____
Dietary restrictions _____
Past medical history? _____
General comments/recommendations _____

◯ Asthma with prescription inhaler • **ASTHMA ACTION PLAN REQUIRED** • form available at www.lycoming.edu/healthservices
◯ Asthma (past history of asthma with no current medications)
◯ Diabetes • **SEE OUR SHARPS DISPOSAL POLICY**
◯ Allergy Injections: allergy shots may be administered in Student Health Services with the following documentation: name of medication, dosage, date of last dose, how often given, any special instructions

STUDENT MUST BRING AN EPIPEN TO ALLERGY INJECTION APPOINTMENTS IN STUDENT HEALTH SERVICES

	NORMAL	NOT EXAMINED	ABNORMAL DESCRIBED FINDINGS
Head, Ears, Nose and Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			# of concussions _____
Skin			
Neuropsychiatry			

◯ **YES,** I will be participating on the _____ team with the Athletic Department
◯ **NO,** I am not an athlete (clearance & sickle cell not required)
◯ **You must provide confirmation of sickle cell trait status,** either through:
1) Existing documentation from routine testing done at birth (contact your state Dept. of Health Newborn Screening Dept)
2) Recent screening lab report (blood work)

◯ **Clearance:**
A. Cleared _____
B. Cleared after completing evaluation / rehabilitation for: _____
C. Not Cleared for: ◯ Collision ◯ Contact ◯ Noncontact ◯ Strenuous ◯ Moderately Strenuous ◯ Nonstrenuous
Due to: _____

Recommendation: _____

HEALTH CARE PROVIDER THAT PERFORMED PHYSICAL EXAMINATION

Date of Examination _____ Printed Name of Physician _____
Signature of Physician _____
Street _____ City _____ State _____ Zip _____
Phone ( ) _____ Fax ( ) _____

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Student Name: _____ Date of Birth_____
LAST FIRST MIDDLE

REQUIRED IMMUNIZATIONS

	1ST DOSE DATE	2ND DOSE DATE	3RD DOSE DATE	4TH DOSE DATE
MMR (Measles/Mumps/Rubella) Two (2) doses given at least 28 days apart				
Tdap (Tetanus/Diphtheria/Pertussis) Within the last 10 years				
Polio				
Hepatitis B Three (3) shot series is required				
Varicella (Chicken Pox) - Two (2) doses given at least 28 days apart or had disease			Year/Age had Chicken Pox:	
Meningitis – Serogroup A,C, Y, W135 (Menactra, Menveo, Menomune) Must be at least one (1) dose given after age 16				

ATTACH IMMUNIZATION DOCUMENTATION

IF VACCINES DATE ARE NOT AVAILABLE

SEROLOGICAL TITERS (blood work) may also be sent as proof of vaccine

IMMUNIZATION RECORDS MAY BE OBTAINED FROM YOUR FAMILY DOCTOR, HIGH SCHOOL OR THE DEPT OF HEALTH

RECOMMENDED VACCINATIONS

	1ST DOSE DATE	2ND DOSE DATE	3RD DOSE DATE	4TH DOSE DATE
Meningococcal B Two (2) doses; dose 1 given between ages 11-12, 2nd (booster) dose given at age 16 or older				
COVID-19 ◯ **Moderna** ◯ **Pfizer** ◯ **Johnson & Johnson**				
HPV (Human Papillomavirus) Two (2) doses given between the ages of 9-26				

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HIPPA COMMUNICATION FORM

(disclosure to self and others)

ONE COLLEGE PLACE | BOX 144 | WILLIAMSPORT, PA 17701-5192 | P: 570.321.4052 | F: 570.321.4355 | EMAIL: health@lycoming.edu

Many patients allow family members (parents, grandparents, guardians, spouse) or close friends to call to discuss medical information, request prescriptions, request copies of medical records, discuss test results, pick up forms, etc. Due to various laws (including HIPAA), our staff cannot provide this information to anyone without the patient's consent except under emergency situations or other special circumstances permitted by privacy laws.

If you wish to have your authorization released to family/friends, you must sign this form. You may revoke this authorization at any time by notifying our office in writing.

Patient Name _____ Date of Birth _____

Patient Phone # ( ) _____

Disclosure to:

Name _____ Relationship _____ Phone # ( ) _____

Name _____ Relationship _____ Phone # ( ) _____

Name _____ Relationship _____ Phone # ( ) _____

Alternate Communication

Health Services uses a variety of ways to communicate important information to you (test results, follow-up appointments, changes to your treatment plan, etc.). These methods include, but may not be limited to, the following: Mail to campus address, mail to home address, email, phone call to home phone, text, or call to cell phone. Unless you otherwise object, brief messages will be left on answering machines/voicemail. Please notify our staff if you would like to make changes to any of the above means of communication.

Patient Signature X _____ Date _____

At your initial visit to Student Health Services you will be provided a copy of our **Notice of Privacy Practices**

You will be asked to initial _____ and date _____ this form at that time indicating receipt.