

# M E M O

**To:** Parents and Students  
**From:** Sondra Stipcak, BSN, RN, Director Health Services  
Townsend Velkoff, MS, Director, Counseling Services  
**RE:** Comprehensive Student Health Record

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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](http://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](http://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 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](http://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](http://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. **Again, please note the Comprehensive Student Health Record is considered complete only with the student signature on the bottom of page 2.**

LYCOMING COLLEGE  
Student Health Services  
700 College Place, Williamsport, Pennsylvania 17701-5192  
Telephone: 570.321.4052 Fax: 570.321.4355

**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.

Answer all questions. Complete the Medical and Mental Health Forms. **Mail all pages to Lycoming College Student Health Services, 700 College Place, Williamsport, Pa. 17701-5192 before July 1 for the Fall semester and January 2 for Spring semester.**

**Biographical Data (to be completed by student)**

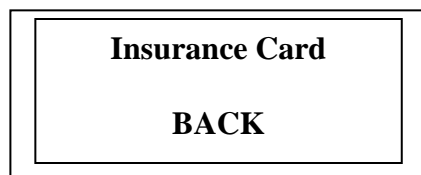
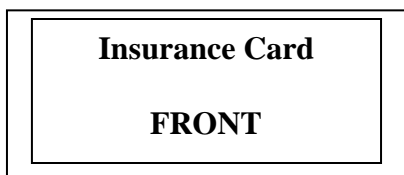
Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ M/F \_\_\_\_\_  
Street Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Place of Birth \_\_\_\_\_ Social Security# \_\_\_\_\_  
Home telephone ( ) \_\_\_\_\_ Student's Cell ( ) \_\_\_\_\_  
Citizenship \_\_\_\_\_ Anticipated year of graduation from Lycoming College \_\_\_\_\_

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

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Home telephone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Business phone ( ) \_\_\_\_\_

**Insurance Information**

***Please attach to this health record 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.***



**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. 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

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**PHYSICAL EXAMINATION**

Temperature	Pulse	Blood Pressure	Height	Weight
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Do abnormalities appear in the following systems:

**NO**      **YES**

**IF YES, PLEASE EXPLAIN**

- |                          |                          |                             |       |
|--------------------------|--------------------------|-----------------------------|-------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head, Ears, Nose and Throat | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory                 | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular              | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal            | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes                        | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Genitourinary               | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Metabolic/Endocrine         | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neuropsychiatry             | _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin                        | _____ |

**Medication Allergies:**

\_\_\_\_\_  
\_\_\_\_\_

**Medications (Name and dosage):**

\_\_\_\_\_  
\_\_\_\_\_

- Asthma with prescription inhaler (Asthma Action Plan Required). Available at [www.lycoming.edu/healthservices](http://www.lycoming.edu/healthservices)
- Asthma (a past history of asthma with no current medications)
- Diabetes

Is this student under treatment for any physical conditions \_\_\_\_\_

Specific recommendations for care of this student \_\_\_\_\_

**TB Risk Assessment**

(To be completed by Health Care Provider)

- |      |   |                              |                             |
|------|---|------------------------------|-----------------------------|
| 1.   | Does the patient have signs or symptoms of active TB?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2.   | Has the patient had close contact with anyone with infectious TB?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3.   | Has the patient had contact with anyone recently in jail, has HIV infection or uses IV drugs?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| 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 <input type="checkbox"/> | No <input type="checkbox"/> |
| 6.   | Is the patient foreign born?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7.   | Has the patient traveled outside the U.S. or Canada?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7(a) | If yes, name of country _____   |                              |                             |
| 8.   | Other indications?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9.   | Has the patient ever had a <b>positive</b> TB skin test?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|      | 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 ( ) \_\_\_\_\_

(DATES REQUIRED – SEE THE BACK OF THIS PAGE)

(IMPORTANT – SPECIAL ATTENTION)

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**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 \_\_\_\_\_
- (f) Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_
- (g) Varicella (chicken pox) vaccine #1 \_\_\_\_\_ #2 \_\_\_\_\_  
or approximate year in school or age of disease \_\_\_\_\_
- (h) Menactra vaccine \_\_\_\_\_ or Menomune \_\_\_\_\_

Printed Name of Physician \_\_\_\_\_

Signature of Physician \_\_\_\_\_

Student's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

**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.**

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

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

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

LYCOMING COLLEGE  
STUDENT HEALTH SERVICES  
FRESHMAN HEALTH RECORD CHECKLIST  
***Top portion for parent/student use only – Not to be returned***

The checklist below is designed to assist parents and students in ensuring all portions of the Comprehensive Student Health Record are completed. Students with incomplete health records will not be able to access their class schedules or obtain books from the bookstore.

- I have completed all four pages of the comprehensive student health record
- I have signed in two places on page #1 and at the bottom of page #2
- I have enclosed a copy (front and back) of my insurance card
- I have taken the yellow sheet (front and back) 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 have a prescription inhaler
  - Filled in dates for ALL REQUIRED vaccinations – 2 MMR’s, a tetanus within the last ten years, meningitis (Menactra or Menomune)), 2 doses of chicken pox vaccine, and 3 doses of Hepatitis B

Immunization Reservation Form

*Return lower portion only if ordering vaccine  
Lycoming College Student Health Services  
700 College Place  
Williamsport, Pa. 17701-5192*

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. However, be advised since all immunizations must be completed prior to the start of classes, students receiving vaccinations on “Check-in day” **will be delayed** in the move-in process. So we are able to have adequate supplies of vaccine please return this form to the Health Center no later than July 1.

Immunizations:

<input type="checkbox"/> Chicken Pox \$65.00	<input type="checkbox"/> Hepatitis B \$35.00 each dose
<input type="checkbox"/> MMR \$40.00	<input type="checkbox"/> Meningitis \$90.00
<input type="checkbox"/> TB Skin Test \$ 5.00	<input type="checkbox"/> Tetanus \$30.00

Student name \_\_\_\_\_

Date \_\_\_\_\_

Payment options on check-in day: cash, check, student ID. Receipts are available for those wishing to submit their own insurance claim forms.

