



**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 January 1 for spring
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.



- 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**

MAIL TO:

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

FAX TO:

570-321-4355

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

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

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

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

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.

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

 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 () _____

Student Name: _____ Date of Birth: _____
LAST
FIRST
MIDDLE
REQUIRED IMMUNIZATIONS

	1 ST DOSE DATE	2 ND DOSE DATE	3 RD DOSE DATE	4 TH 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

	1 ST DOSE DATE	2 ND DOSE DATE	3 RD DOSE DATE	4 TH 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 <input type="radio"/> Moderna <input type="radio"/> Pfizer <input type="radio"/> Johnson & Johnson				
HPV (Human Papillomavirus) Two (2) doses given between the ages of 9-26				

**LEFT
BLANK
INTENTIONALLY**

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.