



**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/ January 1 for spring enrollment to:

MAIL TO:

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

EMAIL TO:

health@lycoming.edu

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.



**LYCOMING
COLLEGE**

Student Health Services

**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 **self reported health history form**

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**

ATHLETES ONLY: Student athletes are required to have a pre-participation physical examination completed by their family physician. The athletic department will assist you with completing additional requirements to participate in athletics.

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**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.

 Student Signature (required) Date 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.

 Student Signature (required) Date 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 _____
- 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.

 Student Signature (required)

 Date

Student Name:

LAST FIRST MIDDLE

Date of Birth _____

HEIGHT

'

"

WEIGHT

ALLERGIES: Please provide name of allergen if you answer yes below.

Latex: Yes No Medication: Yes No _____ Food: Yes No _____

MEDICATION: Please provide a list of all prescribed and supplemental medications below.

| NAME | DOSE | FREQUENCY |
|------|------|-----------|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

SURGERIES: Please list any surgeries you have had in the past.

| SURGERY | AGE AT THE TIME OF SURGERY |
|---------|----------------------------|
| | |
| | |
| | |
| | |

CHECK ANY THAT APPLY: Asthma with prescription inhaler • **ASTHMA ACTION PLAN REQUIRED** • Form available at www.lycoming.edu/healthservices

Diabetes: Type 1 Type 2 • **See our sharps disposal policy**

Allergy injections: allergy injections 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. • **STUDENTS MUST BRING AN EPIPEN TO ALLERGY INJECTION APPOINTMENTS IN STUDENT HEALTH SERVICES.**

NEURO

| | | |
|-------------------------|-------|----|
| Concussion | Yes | No |
| # of concussions | _____ | |
| Headaches/migraines | Yes | No |
| Seizures | Yes | No |
| Stroke | Yes | No |
| Wears glasses/ contacts | Yes | No |

CARDIO

| | | |
|--------------------------|-----|----|
| Blood Clots | Yes | No |
| Chest Pain | Yes | No |
| Congenital Heart Disease | Yes | No |
| High blood pressure | Yes | No |
| High Cholesterol | Yes | No |
| Varicose Veins | Yes | No |

RESP

| | | |
|-----------------------|-----|----|
| Bronchitis | Yes | No |
| Chronic Cough | Yes | No |
| Cystic Fibrosis | Yes | No |
| Frequent Strep Throat | Yes | No |
| Pneumonia | Yes | No |
| Shortness of Breath | Yes | No |
| Tuberculosis | Yes | No |

GI

| | | |
|-----------------|-----|----|
| Acid Reflux | Yes | No |
| Celiacs Disease | Yes | No |
| Constipation | Yes | No |
| Crohn's Disease | Yes | No |
| Gastroparesis | Yes | No |
| Hyperthyroid | Yes | No |
| Hypothyroid | Yes | No |
| Irritable Bowel | Yes | No |

GU

| | | |
|-----------------------------|-------|----|
| Urinary Tract Infections | Yes | No |
| Yeast Infection | Yes | No |
| Sexually Active | Yes | No |
| Number of pregnancies | _____ | |
| Bacterial Vaginosis | Yes | No |
| Polycystic Ovarian Syndrome | Yes | No |
| Polycystic Kidney Disease | Yes | No |

GU

| | | |
|---|-----|----|
| Broken Bones | Yes | No |
| Sports Injuries | Yes | No |
| Do you need an assistive device to help you get around? | Yes | No |
| Other injuries | Yes | No |

SKIN

| | | |
|--|-----|----|
| Eczema | Yes | No |
| Psoriasis | Yes | No |
| Tinea | Yes | No |
| Rashes | Yes | No |
| Other Skin Conditions: please provide name | Yes | No |

Cancer if yes please explain: Yes No

DO YOU:

| | | |
|----------------------|-----|----|
| Smoke/Vape | Yes | No |
| Smokeless tobacco | Yes | No |
| Use Drugs | Yes | No |
| Use Alcohol | Yes | No |
| Use Injectable Drugs | Yes | No |

Please list any other conditions you have been or are currently being treated for:

TB RISK ASSESSMENT
QUESTIONS 1-9 TO BE COMPLETED BY STUDENT

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

- | | | |
|---|-----|----|
| 1. Are you experiencing symptoms of active TB (fever, prolonged cough, coughing up blood, unexplained weight loss, night sweats)? | Yes | No |
| 2. Have you had close contact with anyone with infectious TB? | Yes | No |
| 3. Have you had contact with anyone recently in jail, has HIV infection, or uses IV drugs? | Yes | No |
| 4. Have you resided in, been employed by, or volunteered in a high risk congregate setting (prison, nursing home, hospital, homeless shelter, etc)? | Yes | No |
| 5. Do you have a high risk clinical condition (diabetes, HIV infection, chronic renal failure, low body weight that is 10% below ideal weight)? | Yes | No |
| 6. Were you born outside the United States or Canada? | Yes | No |
| 7. Have you ever traveled outside the United States or Canada? | Yes | No |
| 7a. Name of country traveled to? _____ | | |
| 7b. Length of stay? _____ | | |
| 8. Have you had the BCG vaccine? | Yes | No |
| 9. Have you ever had a positive TB skin test? | | |
| 9a. If yes, when? _____ | | |
| 9b. Date and result of chest x-ray _____ (x-ray report attached) | | |
| 9c. Treatment plan _____ | | |

A 'YES' RESPONSE TO QUESTIONS 1-7 REQUIRES A TB SKIN TEST or IGRA DONE BY A HEALTH CARE PROVIDER

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 Read: _____

(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.

**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.