Welcome to Lycoming College. We hope your years at Lycoming are healthy ones.

Information requested on the Part-Time/Non-Degree 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.

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 you are unable to obtain immunization records, serological titers (blood work) may be sent as proof of vaccinations. Health Services also provides immunizations at a cost. Payment options are cash, check or charge to student ID. Receipts are available for those wishing to submit their own insurance claim forms.

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

- [ ] I have completed the student portion of the Part-time/Non-Degree New Student Health Form
- [ ] I have scheduled an appointment with my family doctor to complete the physical examination and immunization portion of the health form
- [ ] I have taken the physical examination form to my physician for completion
- [ ] If I do not have all of the required immunizations, I have scheduled an appointment with my family doctor to receive missing vaccines.
- [ ] If I have received the COVID-19 vaccine, I have included a copy of my vaccination card.
- [ ] 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 prior to my first class.
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.

Updated 03/08/2022
LYCOMING COLLEGE
Student Health Services
One College Place – Box 144 – Williamsport, PA 17701-5192
Phone 570-321-4052    Fax 570-321-4355    email health@lycoming.edu

# PART-TIME / NON-DEGREE STUDENT HEALTH RECORD

## DEMOGRAPHICS

| Legal Name ____________________________________________________ | Anticipated Graduation Year ___ |
| Preferred Name _____________________________________________ | Date of Birth ________________ |
| Home Address ____________________________________________ | Place of Birth ________________ |
| City ____________________________State ______ Zip ________________ | Sex Assignment at Birth M/F ___ |
| Home Telephone (_____) _____________________________ | Gender Identity ______________ |
| Student Cell (_____) ________________________________ | Preferred Pronoun ____________ |
| Citizenship ________________________________________ | |

## 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

| Name ____________________________________ | Relationship _______ | Cell # ______________________ |
| Daytime Phone ___________________________ | Evening Phone ___________________________ |
| Would your missing person contacts primary language of communication be English? Yes / No | If no, please list preferred language ___________________________ |

## INSURANCE INFORMATION

| Name ____________________________________ | Relationship _______ | Cell # ______________________ |
| Daytime Phone ___________________________ | Evening Phone ___________________________ |
| Would your missing person contacts primary language of communication be English? Yes / No | If no, please list preferred language ___________________________ |

## 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

IF YOU DO NOT HAVE INSURANCE OR YOUR INSURANCE PLAN DOES NOT MEET OUR WAIVER REQUIREMENTS, YOU MUST ENROLL IN THE COLLEGE HEALTH PLAN.
PHYSICAL EXAMINATION
TO BE COMPLETED BY A HEALTH CARE PROVIDER
*a copy of a recent physical within the last 3 years may be substituted*

Student Name ___________________________ Date of Birth ___________________________

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

Medication Allergies: ☐ No ☐ Yes ____________________________
Food Allergies: ☐ No ☐ Yes ____________________________
Dietary restrictions
Is this student under treatment for any physical conditions? ____________________________
General comments/recommendations ____________________________

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

<table>
<thead>
<tr>
<th>Normal</th>
<th>Not examined</th>
<th>Abnormal – Describe Findings</th>
</tr>
</thead>
</table>

Head, Ears, Nose and Throat
Respiratory
Cardiovascular
Gastrointestinal
Eyes
Genitourinary
Musculoskeletal
Metabolic/Endocrine
Neurological # of concussions _____
Skin
Neuropsychiatry

COVID-19 VACCINATION
ATTACH A COPY OF YOUR VACCINE CARD

Dose #1 _______________ Dose #2 _______________ ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson
Booster Date _______________ ☐ Moderna ☐ Pfizer ☐ Johnson & Johnson

REQUIRED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>MMR (Measles/Mumps/Rubella)</th>
<th>1st Dose Date</th>
<th>2nd Dose Date</th>
<th>3rd Dose Date</th>
<th>4th Dose Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two (2) doses given at least 28 days apart (required if born after 1956)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tdap (Tetanus/Diphtheria/Pertussis)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Within the last 10 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Varicella (Chicken Pox)</th>
<th>Year/Age had Chicken Pox:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two (2) doses given at least 28 days apart or had disease</td>
<td></td>
</tr>
</tbody>
</table>

SEROLOGICAL TITERS (blood work) may also be sent as proof of vaccine if records are not available

Date of examination ___________________________
Printed Name of Physician ___________________________
Signature of Physician ___________________________
Street Address ___________________________
City ___________________________ State ______ Zip ______
Phone ___________________________ Fax ___________________________

MAIL FORMS TO: Lycoming College – Student Health Services - or - FAX FORMS TO: 570-321-4355
One College Place, Box 144
Williamsport, PA 17701-5192