LYCOMING COLLEGE

STUDENT HEALTH SERVICES
ONE COLLEGE PLACE
WILLIAMSPORT, PA 17701-5192 PHONE:
570-321-4322 FAX 570-321-4355

PART TIME STUDENT HEALTH RECORD

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________________________________

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

Name____ Relationship______________________________

Home telephone (   )____ Cell (   )________________________________

Business phone (   )____

Health History

1. List any medication allergies:____

2. List all current medication you are taking:____

3. Have you past or present had any of the following conditions:

__________ Heart Disease
__________ Diabetes
__________ Seizures
__________ Asthma
__________ Emotional difficulties
__________ High blood pressure
__________ Gastrointestinal disorders
__________ Musculoskeletal disorders
__________ Environmental allergies

4. Are you currently under treatment for any ongoing medical problems?_________________

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. I also authorize Lycoming College Student Health Center to receive medical records from The Williamsport Hospital ER for the purpose of follow up/ongoing 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

PHYSICAL EXAM

(To be completed by Health Care Provider)

***a copy of a recent physical within the last 3 years may be substituted**

Student Name____ Date of exam_____________

Vital signs: B/P________ HR_______ Height_______ Weight__________

EENT	Normal/Adnormal	Explain______________________________
Mouth/Teeth	Normal/Abnormal	Explain______________________________
Cardiovascular	Normal/Abnormal	Explain______________________________
Pulmonary	Normal/Abnormal	Explain______________________________
Gastrointestinal	Normal/Abnormal	Explain______________________________
Genitourinary	Normal/Abnormal	Explain______________________________
Integument	Normal/Abnormal	Explain______________________________
Lymphatic	Normal/Abnormal	Explain______________________________
Musculoskeletal	Normal/Abnormal	Explain______________________________
Neurological	Normal/Abnormal	Explain______________________________
Psychosocial	Normal/Abnormal	Explain______________________________

Any pertinent past medical history:

Additional Comments:

____________________________________Print Physician Name

____________________________________Physician Signature

____________________________________Physician Phone

Immunizations Required for Part-Time Students:

1. MMR#1_________ #2_________ **or** (**M**)easles#1 ______ (M)easles#2______
   (**M**)umps ______ (M)umps ______
   (**R**)ubella ______ (R)ubella ______

   *required for all individuals born **after** 1956

2. Tetanus _________ or (Tdap) _________ Tetanus/Diphtheria/Pertussis (within the last 10 years)

3. Varicella (chicken pox) vaccine is a (2 dose series) #1__________ #2_________ **or approximate year or age of disease** ________

****Students going on to become full-time students will be required to provide documentation for the following vaccines. These vaccines are highly recommended for our part-time students but not required.**

4. Hepatitis B #1__________ #2__________ #3__________

5. Meningococcal vaccine #1 __________ #2__________ (2nd dose required if 1st dose is given prior to age 16)
   *PA state law requirement of all students living in campus housing.

6. TB Risk Assessment Form (Available at Student Health Services)