

CABRINI COLLEGE STUDENT HEALTH CENTER

CONFIDENTIAL

610 King of Prussia Road • Radnor, PA 19087
Phone (610) 902-8531 • Fax: (610) 902-8282

Please print copy of all forms. Student fills out pages 1 & 2. Once your physician has completed and signed pages 3 & 4, the forms may be delivered, mailed or faxed to the Student Health Center.

CONTACT INFORMATION

Name: _____
Last *First* *Middle*

Soc. Sec. #: _____ **Date of Birth:** _____

College Entrance Date: _____ **Class:** Fr So Jr Sr (please circle)

Gender: _____ **Resident/Commuter** _____

Home address: _____
Number and Street *City* *State* *Zip*

Home phone: _____ **Dorm/Local/Cell phone:** _____

Please list up to three people whom we can contact in case of emergency:

<i>Name</i>	<i>Relationship</i>	<i>Home phone</i>	<i>Work/cell phone</i>

FAMILY HISTORY

<i>Mother</i>		<i>Father</i>	
High Blood Pressure	Thyroid Disease	High Blood Pressure	Thyroid Disease
Heart Disease	Cancer	Heart Disease	Cancer
Diabetes		Diabetes	
Other (specify): _____		Other (specify): _____	

Do you have any allergies to the following? Foods Latex Medications

Please specify: _____

Please list all medications or supplements you are currently taking: _____

Name: _____ Soc. Sec. #: _____

MEDICAL HISTORY					
Please indicate below if you have ever experienced any of these problems by checking "Yes." If you are currently experiencing any of these problems, please check "Currently."					
EYE			URINARY		
Corrective Lenses/Contacts	Yes	Currently	Kidney Stones	Yes	Currently
Other Problems	Yes	Currently	Urinary Tract Infections	Yes	Currently
Other _____			Other _____		
Remarks _____			Remarks _____		
ENT			MUSCULOSKELETAL		
Ear Problems	Yes	Currently	Back Problems	Yes	Currently
Other _____			Disease or Injury of Joints	Yes	Currently
Remarks _____			Other _____		
HEART DISEASE			HEMATOLOGICAL/ ONCOLOGICAL		
High Blood Pressure	Yes	Currently	Anemia	Yes	Currently
Palpitations	Yes	Currently	Cancer	Yes	Currently
Heart Murmur	Yes	Currently	Other _____		
Other _____			Remarks _____		
Remarks _____					
RESPIRATORY			NEUROLOGICAL/PSYCHOLOGICAL		
Shortness of Breath	Yes	Currently	Seizures	Yes	Currently
Asthma	Yes	Currently	Headaches	Yes	Currently
Bronchitis	Yes	Currently	Depression	Yes	Currently
Other _____			Anxiety	Yes	Currently
Remarks _____			Eating Disorder	Yes	Currently
ABDOMINAL			GYNECOLOGICAL		
Irritable Bowel Syndrome	Yes	Currently	Irregular Periods	Yes	Currently
Inflammatory Bowel Disease	Yes	Currently	Severe Cramps	Yes	Currently
Other _____			Ovarian Cyst	Yes	Currently
Remarks _____			Other _____		
ENDOCRINE			Remarks _____		
Diabetes	Yes	Currently			
Thyroid	Yes	Currently			
Other _____					
Remarks _____					

INSURANCE WAIVER

CONFIDENTIAL

I will not be joining the insurance plan offered through Cabrini College because I have comparable coverage through another plan. I fully understand that I am legally responsible for any medical expenses incurred during my enrollment at Cabrini College.

I will notify the Cabrini College Health Services Office if I lose my medical protection.

Full-time students wishing to enroll in the student health insurance plan need not take any action. You will automatically be enrolled and charged for the school health plan if you do not send in a waiver. You will be sent an insurance card directly from the insurance company.

I am currently covered under the following policy:

Insurance Company Name: _____ **Policy #** _____

Group # (if applicable) _____ **Policy Subscriber:** _____

Signature: _____ **Date:** _____

Though the Student Health Center does not bill insurance companies, we require that you send front and back copies of insurance and prescription cards in case of emergency.

**CABRINI COLLEGE
STUDENT HEALTH CENTER
PHYSICAL EXAMINATION FORM**

610 King of Prussia Road Radnor, PA 19087 Phone: (610) 902-8531 • Fax: (610) 902-8282

Patient's Name: _____

Soc. Sec. #: _____

TO THE EXAMINING CLINICIAN

Please review the patient's history, complete this form and comment on all positive answers.

BP	/		Height		Weight					
CBC	HgB		HcT		WBC		RBC		Platelets	

(optional)

Physical Exam:

Eyes	WNL	Remarks:	
Ears	WNL	Remarks:	
Nose	WNL	Remarks:	
Throat	WNL	Remarks:	
Neck	WNL	Remarks:	
Lungs	WNL	Remarks:	
Heart	WNL	Remarks:	
Abdomen	WNL	Remarks:	
Lymph glands	WNL	Remarks:	
G.U.	WNL	Remarks:	
Skin	WNL	Remarks:	
Neuro	WNL	Remarks:	
Musculoskeletal	WNL	Remarks:	

Current Medications: _____

Is this patient medically qualified to participate in intracollegiate, intramural or club sport activities? **Yes** **No**

Clinician's Signature: _____ Date Exam was completed: _____

Clinician's Printed Name: _____

Clinician's Address _____

Clinician's Phone # _____ Clinician's Fax # _____

REQUIRED IMMUNIZATIONS
 Immunizations Required Prior to Beginning Classes
 Please Fill in Dates

	1 st	2 nd	3 rd	4 th	5 th
MMR – Must have 2 injections, both after 1st birthday & at least 30 days apart					
Polio – Minimum of 3 doses for all students 18 and under					
DPT – 3 or more doses required					
DPT / TdaP / Td – tetanus booster must be within last 10 years					
Hepatitis B – series of 3					
Varicella (chicken pox) – Date of disease OR If no history of disease, 2 doses required after age 13					

Tuberculosis Screening¹

1. Is the student a member of a high-risk group or is the student entering the health professions?¹

Yes _____ No _____

If No, stop. If yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] Tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high risk group.

2. Tuberculin skin test:

Date given: ____/____/____ Date read: ____/____/____

Result: _____ (Record actual mm of induration, transverse diameter; if no duration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive _____ negative _____

3. Chest X-Ray (required if tuberculin skin test is positive) result: normal _____ abnormal _____

Date of chest X-Ray: ____/____/____

Meningitis

Vaccine OR waiver is required of all Cabrini College Housing students

Date of vaccination :

Menomune ____/____/____
 (Quadrivalent polysaccharide vaccine)

Menactra ____/____/____
 (Polysaccharide Diphtheria Toxoid Conjugate Vaccine)

MENINGITIS INFORMATION RESPONSE – Required of all **resident** students (Check either #1 or #2)

1. _____ I have had the meningococcal meningitis immunization.

2. _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that I will **NOT** obtain immunization against meningococcal meningitis disease.

SIGNATURE OF STUDENT REQUIRED: _____
 (OR PARENT/GUARDIAN IF STUDENT IS UNDER AGE 18)

Clinician's initials that information above is correct _____

¹ Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥15 mg/d for ≥1 month) or other immunosuppressive disorders.