SHIPPENSBURG UNIVERSITY STUDENT HEALTH RECORD

Please print clearly.

New or transferring student - semester & year of entrance: _____

NAME_____SEX: M OR F
LAST *FIRST* *MIDDLE*

ADDRESS _____
STREET *CITY* *STATE* *ZIP*

HOME PHONE_____ CELL PHONE_____

BIRTH DATE_____ SU ID #_____

MARITAL STATUS __Single __Married Maiden Name (if applicable) _____

EMERGENCY NOTIFICATION:

Name_____ Relationship _____

Address_____
STREET *CITY* *STATE* *ZIP*

Home Phone _____ Cell Phone _____

ACCIDENT AND/OR HEALTH INSURANCE: *(Please write "none" if no insurance)*

Name of Company _____

Address_____
STREET *CITY* *STATE* *ZIP* *PHONE*

Group No._____ ID No._____

This form becomes part of your permanent health file. You may want to consider keeping a copy of this information, once complete, for future reference. The immunizations are a required attachment for our health form. This completed form **MUST BE RETURNED** to the university to complete the admissions process.

Please MAIL ORIGINAL TWO PAGE FORM BY AUGUST 1 of entering year:

ETTER HEALTH CENTER
SHIPPENSBURG UNIVERSITY
1871 OLD MAIN DRIVE
SHIPPENSBURG, PA 17257
PHONE: (717) 477-1458
FAX: (717) 477-4042

Shippensburg University Etter Health Center
Office Use ONLY:
Chart Review:
☐ Complete – Date: _____
☐ Incomplete
Reason:

(Continued)

Name:_____**Date of Birth:** _____

Immunization Record – Please attach a copy of your immunization record(s). The university health center advises that you have all of the vaccines recommended for your age. These can be found at http://www2a.cdc.gov/nip/adultimmsched/.

Do you live in campus housing? If "Yes" please visit the following website to ensure your compliance with Meningitis requirements. https://www.ship.edu/Health_Center/Meningitis/

Personal History - Please answer ALL questions. Give year for all "Yes" answers and details below.

Have You Had The Following?	**Yes**	**No**		**Yes**	**No**		**Yes**	**No**
Eye			**Social**			**Endocrine**		
Visual Loss			Tobacco Use			Diabetes		
Corrective Lenses/Contacts			"Street" Drug Use			Thyroid Problems		
Cardiovascular			**Musculoskeletal**			**Urinary**		
Heart Murmur			Arthritis			Kidney Disease		
High Blood Pressure			Hernia			Bladder/Kidney Infection		
Heart Disease			Muscular dystrophy			Kidney Stones		
Ear, Nose, Throat; Respiratory			**Reproductive**			**Dermatology**		
Hearing Loss			Polycystic Ovarian Disease			Eczema		
Nasal Allergies			STD/STI			Psoriasis		
Gastrointestinal			**Neurological/Psychological**			**Hematological**		
Irritable Bowel Syndrome			Fainting Episodes			Anemia		
Esophageal Reflux			Migraines			Blood Clotting Disorder		
Gluten Sensitivity			Anxiety/Depression			Bleeding Disorder		
Hemorrhoids			Insomnia			Sickle Cell Anemia		
Crohn's Disease			Head Injury or Concussion			**Miscellaneous**		
Ulcerative Colitis			Seizures			Speech Defect		
			ADD/ADHD			Learning Disability		
			Eating Disorder					

Medications Currently Taking: _____

Medication Allergies (please list, if any): _____

Prior Surgeries/Hospitalizations (please list, if any): _____

Other Pertinent Health History: _____

_____

Student Signature ***Date***

(Continued)

Name: _____ Date of Birth: _____

FAMILY HISTORY:

Are any of your immediate family members deceased? Yes _____ No _____

If yes, please provide the relationship, cause, and age of the family member when this occurred.

_____.

Indicate if there is any history of the following in your family (brother, sister, father, mother, grandfather, grandmother, etc.)**:**

	Yes	No	Relationship		Yes	No	Relationship
Diabetes				Epilepsy, Convulsions			
Hypertension				Sickle Cell Disease			
Heart Disease				Kidney Disease			
Sudden Cardiac Death before age 50				Tuberculosis			
Thyroid Disease				Mental Disorder (please specify)			
Cancer				Other			

CONSENT/AUTHORIZATION FOR TREATMENT

I verify that the information provided on this **Medical History** form is true and complete to the best of my knowledge. I give consent for the medical staff of Shippensburg University, or their authorized representative, to treat my son, daughter, or self as deemed medically necessary. This may include examination, injections, treatments, immunizations, or other therapies as needed.

This permission is granted with the understanding that in the event of serious illness or medical emergency, the student will be transported to the nearest appropriate health care facility for treatment as deemed necessary. During a medical emergency every possible effort will be made to notify the emergency contact person listed on this **Medical History** form. Failure in such efforts will not prevent the physician from providing emergency treatment that is necessary and in the best interest of the life of the student. All bills incurred will be the responsibility of the student.

_____ _____ _____

Student Signature ***Date*** ***Parent/Guardian Signature (If student is under 18)***

CONFIDENTIALITY

All health information is private and confidential. As a consumer of the Shippensburg University Health Services, confidentiality is your right. Therefore, all information on this form is confidential and for use by the Etter Health Center staff. Should you choose to have information about you released to a third party (parent, guardian, insurance company, etc.) it will be done with your consent only. Unless we are required by law to release your information, it will occur only with your written consent.

- ❖ I grant permission to SU Health Services to discuss my health information, which may be by phone or fax, with the following **person(s)**: _____
  - ☐ Yes, to the above person(s). ***(Name/Relationship)***
  - ☐ None at this time
- ❖ I understand the above paragraph about confidentiality.

_____ _____ _____

Student Signature ***Date*** ***Print Name***