POINT PARK UNIVERSITY
Student Health Center

201 Wood Street Pittsburgh, PA 15222 ATTN: Student Health Center
Phone: 412-392-3800 | FAX: 412-392-3801 | www.pointpark.edu

STUDENT HEALTH RECORD – PART ONE

This document is **MANDATORY** for all full-time students. You ***will not be fully registered*** until the Student Health Center receives this **completed form AND proof of REQUIRED IMMUNIZATIONS**. Please return this important piece of your medical record to the address or secure FAX number listed above. **Please keep a copy for your own records!**

Name: Last _____ First _____ Middle _____

Date of Birth: ___/___/___ **Gender:** _____ **Term Starting at PPU:** Fall 20 _____ *or* Spring 20 _____

Phone Numbers: Student's Cell # _____ Home phone # _____

Addresses: While at University _____
(Specify "Dorm" *or* list your Street Address if residing off-campus)

Home _____
(Street Address, City, State, Zip Code and Country, if other than the U.S.)

Major: _____ **Student Athlete?** Yes _____ No _____ If yes, which sport? _____

Emergency Contact Information:

Name _____ Relationship _____ Phone # _____

Medical History:

- Do you have any health conditions or medical concerns? (for example: seizures, asthma, surgical history, diabetes, injuries, etc.) Yes _____ No _____ If yes, please explain: _____
- Do you take any medications regularly? Yes _____ No _____ If yes, please list them: _____
- Are you allergic to any medication or have any other allergies? (for example: penicillin, bee stings, specific foods, seasonal, etc.) Yes _____ No _____ If yes, please list them: _____
- Is there any other information that would be helpful in providing you with healthcare? (Include physical limitations) Yes _____ No _____ If yes, please explain: _____

Statement and Consent:

- I give my permission for diagnostic tests or therapeutic treatments as deemed necessary by the University professional medical staff.
- It is understood that I will assume all financial obligations which are not covered by my personal health insurance plan.
- I am aware that a copy of applicable HIPAA documentation (privacy rights) may be obtained from the Student Health Center.

_____ Student's Signature

___/___/___ Date

_____ Signature of parent or guardian
(if student is under 18 years of age)

PLEASE NOTE : Information provided on this record will have no effect upon your position at Point Park University. This information is confidential and will be used only if necessary by the STUDENT HEALTH CENTER as an aid to providing necessary health care while you are a student, and will not be released to anyone without your knowledge and consent. A "consent to release information" document must be signed by the student in order for medical staff to speak with anyone, other than the student, regarding Student Health Center visits or any medical care provided or initiated by such.

PART TWO ON BACK (MUST be COMPLETED)

Revised 02/11/14

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STUDENT HEALTH RECORD - PART TWO

Name: Last _____ First _____ Middle _____

REQUIRED IMMUNIZATIONS:

ALL FULL-TIME STUDENTS born after January 1, 1957 are REQUIRED to provide documentation (in English) of having the following immunizations PRIOR to entering Point Park University :

- **MMR** (Measles, Mumps, Rubella) Two doses are mandatory, given at least one month apart:
  (NOTE: Titers are also acceptable as proof of immunization. A titer is a blood test that verifies immunity to a disease. A copy of the titer results, **IN ENGLISH**, must accompany this form for review.)
  Dose 1 Received: ___/___/___ Dose 2 Received: ___/___/___

- **Meningitis** (MCV4) One dose is required by Pennsylvania law for students residing in campus housing:
  (Booster recommended by CDC if first dose was given PRIOR to the 16th birthday)
  Dose 1 Received: ___/___/___ Booster Received: ___/___/___

MENINGOCOCCAL DISEASE CAN REFER TO ANY ILLNESS THAT IS CAUSED BY THE TYPE OF BACTERIA CALLED *NEISSERIA MENINGITIDIS*, ALSO KNOWN AS MENINGOCOCCUS. THE ILLNESS MOST PEOPLE ARE FAMILIAR WITH IS MENINGOCOCCAL MENINGITIS, WHICH PEOPLE SOMETIMES JUST CALL "MENINGITIS." THIS USUALLY MEANS THE LINING OF THE BRAIN AND SPINAL CORD HAVE BECOME INFECTED WITH THESE BACTERIA. BUT THESE BACTERIA CAN ALSO CAUSE OTHER SEVERE ILLNESSES, LIKE BLOODSTREAM INFECTIONS (BACTEREMIA OR SEPTICEMIA). MENINGOCOCCUS BACTERIA ARE SPREAD THROUGH THE EXCHANGE OF RESPIRATORY AND THROAT SECRETIONS LIKE SPIT (E.G., LIVING IN CLOSE QUARTERS, KISSING). ALTHOUGH IT CAN BE VERY SERIOUS, MENINGOCOCCAL DISEASE CAN BE TREATED WITH ANTIBIOTICS THAT PREVENT SEVERE ILLNESS AND REDUCE THE SPREAD OF INFECTION FROM PERSON TO PERSON. QUICK MEDICAL ATTENTION IS EXTREMELY IMPORTANT IF MENINGOCOCCAL DISEASE IS SUSPECTED. KEEPING UP TO DATE WITH RECOMMENDED VACCINES IS THE BEST DEFENSE AGAINST MENINGOCOCCAL DISEASE. MAINTAINING HEALTHY HABITS, LIKE GETTING PLENTY OF REST AND NOT COMING INTO CLOSE CONTACT WITH PEOPLE WHO ARE SICK, CAN ALSO HELP.
Source: www.cdc.gov website

- **Tuberculin (TB) Skin Test** Required for INTERNATIONAL students ONLY (**MUST** be within the past year):
  Date test planted: ___/___/___ Date test read: ___/___/___ (**MUST** be 48 – 72 hours later)
  Result (mm of induration): _____ Interpretation: POSITIVE* _____ NEGATIVE _____
  *If positive TB test, chest X-Ray is REQUIRED (provide copy of report **IN ENGLISH**) Date: ___/___/___

The above data MUST be verified by a physician's signature *OR* by providing immunization documentation, which may include: physician's office records, clinic records, previous school records, military records (DD-214), etc. Please keep a copy of all documentation for your personal records.

Physician's Name (please print) _____ Physician's signature _____ Date _____

Physician's address & phone number _____

RECOMMENDED IMMUNIZATIONS:

Not required by the University, but strongly recommended.

- DTaP (Diphtheria, Tetanus, Pertussis): Primary series of 4 doses, typically received in childhood
- TDaP Booster: Recommended every 10 years
- Varicella (chicken pox): If no history of having the disease
- Hepatitis B series: Series of 3 doses given over a six month period.

Failure to submit proper immunization documentation will result in the student's ineligibility to register for classes.

Revised 02/11/14