HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY (Side 1)
STUDENT: Please complete Side 1 of form and have a physician complete Side 2. Once both sides are complete, return it to:

Wellness Center
125 Clinton Street, Suite W0002
Mansfield University
Mansfield, PA 16933

Last First MI Maiden Name:		Student ID#	Social Security #
Box/Apt. Street/Road City State Zip Code Full Address:			
Date of Birth: Gender: M F	Student Cell Phone #: ( )		Major:
Last First MI Next of Kin:	Relationship:		Home Phone # ( ) Work Phone # ( )
Street City State Zip Code Address:			
Country of Citizenship? Are you a veteran? If yes, Branch: If yes, Length of Service:			
Please complete the following information to aid in treating you should an accident occur or uncovered service is needed while attending Mansfield University			
INSURANCE INFORMATION REQUIRED (OR COPY OF INSURANCE CARD, FRONT AND BACK, MAY BE ATTACHED			
Last First MI Name of Policyholder:		Policyholder's Social Security #	Policyholder's Date of Birth:
Name of Policyholder's Employer:			
Street City State Zip Code Employer's Address:			
Name of Insurance Company:			
Street City State Zip Code Insurance Co. Address:			
Phone # of member services:	Effective date of card:		Group #:
ID#	(circle one) RX Plan: Yes No		(circle one) HMO: Yes No
Preauthorization Phone #: (Inpatient:) (Outpatient:)			
Last First MI Primary Care Provider:			Phone #: ( )

(IT IS THE RESPONSIBILITY OF THE STUDENT OR PARENT TO NOTIFY US OF ANY CHANGE IN INSURANCE COVERAGE).

The information on this form is strictly for the use of the health services and will not be released to anyone without your knowledge and consent.

(-OVER-)

HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY (Side 2)

Unanswered questions or incomplete blanks will require the form to be returned.

Examining Physician: This student has been accepted. Please review and complete.

Last	First	M.I.	(Circle One)
Name:			Gender : M F

Height:	Weight:	B/P:	Pulse:	Resp:
Vision OS OD			Glasses/Contacts:	Colorblind: Yes No
Hearing AS AD				Hearing Aids: Yes No

Urine DIP Glucose Protein Hgb./Hct (if indicated)

Describe fully, use extra sheet, if needed.

Does patient have a history of:	Yes	No	Explanation	Does patient or blood relation have a history of:	Yes	No	Explanation
HIV/AIDS				Asthma or Hay Fever			
Injuries				Surgeries			
Head Injury w/loss of consciousness				Alcohol or Drug			
Loss or serious impairment of organs				Mental or Emotional Disorder			
Menstrual Disorder				Suicide Attempt			
Tobacco Use				Migraine H.A.			
Eating Disorder				Hypertension			
STD				Convulsions or Epilepsy			
Mono				Cancer			
Hepatitis				Diabetes			
Attention Deficit				Irritable Bowel			
Cystitis-recurrent				Sinusitis-Chronic			
Ovarian Cyst				Polycystic Ovary Disease			
Tuberculosis				Heart Disease or Murmur			

Physical Exam: Are there any abnormalities of the following: Describe fully.

Skin	Heart
Lymph Nodes	Abdomen
HEENT	Genital-urinary
Lungs	Musculoskeletal
Breast	Neuro

Immunization Record – Please review and update if needed (all areas marked with an asterisk (*) are REQUIRED)

*Tuberculosis (TB) Screening Test – **Required only of persons at high risk for TB** as defined by the Centers for Disease Control (foreign born persons , persons with compromised immune systems, close contacts of infectious TB cases, etc). **PPD (Mantoux) must be administered within the past 6 months. ____ No, I am not at high risk for TB. ____ Yes, I am at high risk for TB as defined by Centers for Disease Control.**

Date Given: _____ Result (**must include mm induration**): _____ Date Read: _____ Read By:_____

If results ≥ 5 mm induration, the following is **REQUIRED:**

Chest X-Ray **within the past 6 months**: Date: _____ **Chest X-Ray Result**: Normal _____ Abnormal_____

-OR- Documentation of INH Therapy: Date Begin: _____ Date Completed: _____

Exception: The Pennsylvania Department of Education requires that all Education majors provide a negative TB result.

Hepatitis B #1 date: _____ Hepatitis B #2 date: _____ Hepatitis B #3 date: _____

-OR- Positive Hepatitis B titre date: _____ *Tetanus date: _____

*MMR#1 date: _____ *MMRR#2 date: _____ **-OR-** MMR titre date _____

Meningitis date: #1_____, #2 (If Needed)_____ Gardasil date: #1_____, #2_____, #3_____

*Varicella (chickenpox disease): _____ **-OR-** Vaccine date: #1 _____, #2 _____ **-OR-** Positive titer date: _____

Allergies to medicine and type of reaction:

Other allergies: food, insects, latex, etc.:

Current Medications and dosages:

Provider's Name: Address: Phone #

Signature:	**Exam Date:**