HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY

STUDENT: Please complete Side (1) of form and have a physician complete Side (2). Once both sides are complete, return entire form to:

Mansfield University
Campus Clinic
125 Clinton Street, Suite W0002
Mansfield, PA 16933

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Maiden</th>
<th>Preferred Name</th>
<th>Student ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full Address:</td>
<td>Box/Apt.</td>
<td>Street/Road</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Gender:</td>
<td>M</td>
<td>F</td>
<td>Student Cell Phone #:</td>
<td>Major:</td>
<td></td>
</tr>
<tr>
<td>Next of Kin:</td>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>Relationship:</td>
<td>Home Phone #:</td>
<td>Work Phone #:</td>
</tr>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Country of Citizenship?</td>
<td>Are you a veteran?</td>
<td>If yes, Branch:</td>
<td>If yes, Length of Service:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Policyholder’s Social Security #</th>
<th>Policyholder’s Date of Birth:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Policyholder:</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Name of Policyholder’s Employer:</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Employer’s Address:</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Name of Insurance Company:</td>
<td>Street</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
<tr>
<td>Insurance Co. Address:</td>
<td>Phone # of member services:</td>
<td>Effective date of card:</td>
<td>Group #:</td>
<td></td>
</tr>
<tr>
<td>ID#:</td>
<td>(circle one)</td>
<td>RX Plan:</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Preauthorization Phone #:</td>
<td>(Inpatient:</td>
<td>(Outpatient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Provider:</td>
<td>Last</td>
<td>First</td>
<td>MI</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

( 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.

Continue to Side (2)
HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY (Side 2)

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

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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Last</th>
<th>First</th>
<th>M.I.</th>
<th>Date of birth</th>
<th>[Circle One]</th>
<th>Gender:</th>
<th>M</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height:</td>
<td>Weight:</td>
<td>B/P:</td>
<td>Pulse:</td>
<td>Resp:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision</td>
<td>OS</td>
<td>OD</td>
<td>Glasses/Contacts:</td>
<td>Colorblind:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>AS</td>
<td>AD</td>
<td>Hearing Aids:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hgb./Hct (if indicated)

Describe fully, use extra sheet, if needed.

Does patient have a history of: Yes | No
---|---
HIV/AIDS
Injuries
Head Injury w/loss of consciousness
Loss or serious impairment of organs
Menstrual Disorder
Tobacco Use
Eating Disorder
STD
Mono
Hepatitis
Attention Deficit
Cystitis-recurrent
Ovarian Cyst
Tuberculosis

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: _______, #2 date: _______, #3 date: _______

- OR - Positive Hepatitis B titre date:__________

*MMR#1 date: _______, *MMR#2 date: _______, -OR- MMR titre date__________

Hepatitis B #1 date: _______, #2 date: _______, #3 date: _______

- OR - Positive Hepatitis B 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: