CONFIDENTIAL MANDATORY HEALTH FORM

Mail this form to:
UPG Health Center
216 Chambers Hall
150 Finoli Drive
Greensburg, PA 15601

UNIVERSITY HEALTH CENTER
UNIVERSITY OF PITTSBURGH AT GREENSBURG

Phone: (724) 836-9947
Fax: (724) 836-7907

Please print or type all entries.

Last Name	First Name	MI	Entering Status			
			Freshman	Sophomore	Junior	Senior
PeopleSoft Number	Birth date	Marital Status		Gender		Living Status
		Single Married		Male Female		Resident Commuter
Student Mailing address- number and street	City	State	Zip Code	Cell Phone Number		
Person to notify in case of emergency		Relationship to student				
Address if different from above		Emergency Contact Phone Number				
		Home # _____ Work # _____				
Hospitalization Insurance Company Name	Subscriber	Member ID #		Group No.		

Please enclose a photocopy, front and back, of your insurance card*

A. Are you currently under a doctor's care for <u>any</u> health problem? Yes_____No_____
If yes, please describe. _____
_____

B. Are you allergic to medications, x-ray dye, or other substances? (Give drug name, date, and describe reaction if known.)
Yes _____ No_____ Describe _____
_____
Do you have any other allergies? Yes _____ No _____ Describe _____
_____

C. Do you take any medications regularly? If yes, please list them (include allergy shots, prescription, nonprescription drugs, birth control pills or antidepressants.) _____
_____

D. Past Medical History and review of systems: Please check any/all you have had or are currently having problems.

	Abdominal discomfort		Changes in urinating		Headaches		Pneumonia
	Alcohol/drug abuse		Chest pain/tightness		Heart disease		Rheumatic fever
	Anemia		Colitis		Hemorrhoids		Sexually transmitted diseases
	Anxiety		Constipation		Hepatitis or jaundice		Shortness of breath
	Arthritis		Diabetes		High blood pressure		Skin disease
	Asthma		Diarrhea		Indigestion		Swollen ankles
	Blood disorders		Depression		Kidney disease		Thyroid disease
	Blood in stool		Gall bladder disease		Lightheadedness		Tuberculosis
	Bronchitis		Gout		Lower back pain		Ulcers
	Cancer		Hay fever		Nausea		Unexplained weight/loss gain
	Changes in bowel habits		Head or neck radiation		Palpitations		Vomiting

E. Are there any other issues that you wish to share with us? _____
_____

Printed Name of Student _____ **Signature of Student** _____

Date Signed _____

Office use only:

Date Received		Received by	

Failure to return this form will result in an immunization hold on your account and prevent registration spring classes.

Revised: January 2010

PART I: REQUIRED

M.M.R. (MEASLES, MUMPS, RUBELLA) (Two doses required. Titers are also acceptable as proof of immunization. A titer is a test that verifies immunity to a disease. A copy of titer results must accompany this form for review. If you are sending titer results, you are not required to fill out MMR dates.)

DOSE 1: ___/___/___ (12 15 months or later)

DOSE 2: ___/___/___ (4 6 years or later, and at least one month after first dose)

MENINGOCOCCAL TETRAVALENT (One dose is required for students living in dormitories/residence halls)

TETRAVALENT CONJUGATE (preferred) ___/___/___

TETRAVALENT POLYSACCHARIDE (acceptable alternative if conjugate not available; revaccinate every three to five years if increased risk continues) ___/___/___ ___/___/___

PART II: RECOMMENDED

TETANUS-DIPTHERIA (Primary series with DTaP or DTP and booster with Td in the last 10 years meets requirement.)

PRIMARY SERIES OF FOUR DOSES WITH DTaP OR DTP:

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

TETANUS-DIPTHERIA (Td or Tdap) BOOSTER WITHIN THE LAST 10 YEARS: ___/___/___

POLIO (Primary series in childhood meets requirement; three primary series schedules are acceptable.)

OPV ALONE (oral Sabin three doses) : #1 ___/___/___ #2 ___/___/___ #3___/___/___

IPV/OPV sequential: IPV #1 ___/___/___ IPV #2 ___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___

IPV ALONE (injected Salk four doses) #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

VARICELLA (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart)

HISTORY OF DISEASE YES ___ NO ___

VARICELLA ANTIBODY ___/___/___ REACTIVE ___ NONREACTIVE ___

IMMUNIZATION: DOSE #1 ___/___/___ DOSE #2 ___/___/___

QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (Three doses of vaccine)

DOSE 1: ___/___/___ DOSE 2: ___/___/___ DOSE 3: ___/___/___

HEPATITIS B (Three doses of vaccine or two doses of adult vaccine in adolescents 11 15 years of age, or a positive Hepatitis B surface antibody)

IMMUNIZATION (Hepatitis B)

DOSE 1: ___/___/___ DOSE 2: ___/___/___ DOSE 3: ___/___/___

IMMUNIZATION (Combined Hepatitis A and B Vaccine)

DOSE 1: ___/___/___ DOSE 2: ___/___/___ DOSE 3: ___/___/___

HEPATITIS B SURFACE ANTIBODY: ___/___/___ RESULT REACTIVE ___ NONREACTIVE ___

HEPATITIS A

IMMUNIZATION (Hepatitis A)

DOSE 1: ___/___/___ DOSE 2: ___/___/___

IMMUNIZATION (Combined Hepatitis A and B Vaccine)

DOSE 1: ___/___/___ DOSE 2: ___/___/___ DOSE 3:___/___/___

PART III: FOR HIGH-RISK GROUPS ONLY

(Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. 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 jejunoileal bypass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g., prednisone 15 mg/d for one month) or other immunosuppressive disorders.)

PNEUMOCOCCAL POLYSACCHARIDE VACCINE ___/___/___

TUBERCULOSIS SCREENING

TUBERCULIN SKIN TEST: DATE GIVEN: ___/___/___ DATE READ: ___/___/___

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

INTERPRETATION (based on mm of induration as well as risk factors): POSITIVE ___ NEGATIVE ___

CHEST X-RAY (Required if tuberculin skin test is positive)

RESULT: NORMAL ___ ABNORMAL ___

DATE OF CHEST X-RAY: ___/___/___

PART V: IMMUNIZATION EXEMPTIONS

A written exemption statement must be returned to the Student Health Service for review. Please be aware, if an outbreak of measles, mumps, or rubella occurs, the State Health Department may exclude students from classes who do not provide proof of immunity to these diseases.
If applicable, please check one of the following immunization exemptions:

_____ **MEDICAL** (An exemption may be granted based on a written statement from a physician, or a designee, that the immunization(s) may be detrimental to the health of the student.)

_____ **RELIGIOUS/MORAL/ETHICAL** (An exemption may be granted based on a student s written objection to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief.