

**CONFIDENTIAL MANDATORY HEALTH FORM
UNIVERSITY HEALTH CENTER
UNIVERSITY OF PITTSBURGH AT GREENSBURG**

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

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

Please print or type all entries.

Last Name		First Name		MI	Entering Status	
					Freshman Junior	Sophomore Senior
PeopleSoft Number		Birth date		Marital Status		Gender
				Single Married		Male Female
						Living Status
						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 any health problem? Yes ___ No ___ If yes, please describe. _____

Please provide documentation of required care, if any, necessary with this particular problem.

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.

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

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

Printed Name of Student _____ Signature of Student _____

Date Signed _____

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

Office use only:

Date Received		Received by	
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Please complete both sides of form.

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):
___/___/___ ___/___/___

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: ___/___/___

COVID-19 VACCINE:

TYPE: _____ #1 ___/___/___ #2 ___/___/___ BOOSTER ___/___/___

PART II: RECOMMENDED

TETANUS-DIPHTHERIA (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-DIPHTHERIA (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: ___/___/___

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 jejunioileal 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.)