1145 King Road, Immaculata, Pennsylvania 19345
STUDENT HEALTH SERVICES • 484-323-3500

Pre Entrance Requirement

This form is to be completed **IN FULL** and returned to the above address.
****MUST SIGN WHERE INDICATED.**

Student Contact Information

Full Name:____

Address______________________________________ Home Phone______________________

City__________________ State______ Zip________ Cell Phone________________________

Date of Birth_______________ Student ID Number____________________________________

Class: FR____ SO____ JR____ SR____ Grad____ CLL ____

Resident_____ Commuter (living at home)____ Off Campus(local apt. **not** IU housing)_____

Please list 3 people we can contact in case of emergency:

Name	Relationship	Home phone	Cell/work phone

Confidentiality and Consent

The information on this health form is legally privileged and confidential and is intended only for the use of the Immaculata University Student Health Services department. The copying or distributing of this document is prohibited. Access to clinical information is limited to Health Services staff.

I certify that this information is true and complete to the best of my knowledge. I will notify Student Health Services of any change in my health information. I agree to the release of pertinent information from my health record in the event of a valid medical emergency.

****Signature of Student**____

** ** (Parent or Guardian if student is under 18)**

CONFIDENTIAL DO NOT COPY

Name____ **D.O.B.**_________________

Family History (please circle)

Mother	Father
High Blood Pressure Heart Disease Diabetes Cancer (location)_________________ Other ___________________________ Living_____ Deceased________	High Blood Pressure Heart Disease Diabetes Cancer (location)__________________ Other_____________________________ Living_____ Deceased_________

Personal History (Please check Yes or No)

	Y	N		Y	N
Asthma			ADD/ADHD		
Chronic cough			Concussion		
Shortness of Breath			Dizziness/Fainting		
High Blood Pressure			Headache(recurrent/migraine)		
Heart Disease			Anxiety		
Heart Murmur			Depression		
Heart Palpitations			Eating Disorder		
Chicken Pox			Alcohol/Drug Dependency		
Measles			Diabetes		
Mumps			STD/STI		
Mononucleosis			***Females Only***		
Rheumatic Fever			Severe Cramps		
Tuberculosis			Excessive Flow		
Kidney Disease			Irregular Periods		
Gallbladder Problems			Frequent UTI's		
Diarrhea (recurrent)			***Males Only***		
Back problems			Testicular Problems		
Disease or injury to joints			Hernia		

Please list Allergies food, drug or latex

____

Please give explanation of all above items for which you have answered yes

____

____

Please list any hospitalizations/ surgeries____

____

Current medications____

____

Name____ **D.O.B.**__________________

Required Immunizations

These immunizations are **REQUIRED** for registration.
Medical/Religious contraindication or exemption: ____________________________________

Tdap Must be within 10 yrs. Date of vaccination ____/____/____
(Tetanus, diphtheria and pertussis)

****Meningitis** Date of vaccination____/____/____
(Must have booster if first shot was prior to age 16) Date of booster ____/____/____

_** Failure to comply with state required meningitis vaccine policy for residential students will result in a hold on your housing status. Signature Required below.

1. _____ I have received the meningitis vaccine.
2. _____ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of the disease and the availability and effectiveness of the vaccine and have decided **NOT** to obtain immunization against meningococcal meningitis disease.

****SIGNATURE OF STUDENT REQUIRED: ___________________________ Date:___________**
(PARENT/ GUARDIAN IF STUDENT IS UNDER AGE 18)

Other Immunizations

MMR Date of vaccine Dose #1___/___/___ Dose #2___/___/___
(Measles, Mumps and Rubella)

Varicella/Chicken Pox Date of vaccine Dose #1 ___/___/___ Dose #2___/___/___

Polio; please circle oral or injection Date of vaccine Dose #1___/___/___ Dose #2___/___/___
Date of vaccine Dose #3___/___/___ Dose #4___/___/___

Hepatitis B Vaccine Date of vaccine Dose #1___/___/___ Dose #2___/___/___
Date of vaccine Dose #3___/___/___