**To maintain confidentiality, please print, complete and either mail or fax this entire form directly to:**

**ADMISSIONS OFFICE**
**Geneva College**
**3200 College Ave**
**Beaver Falls, PA 15010**
**Fax No: 724-847-6776**

**Fall Semester Deadline: May 31, 2013**
**Spring Semester Deadline: December 15, 2013**

GENEVA COLLEGE

***Students:***

- *Please complete pages 1,2,3,4 and 7 prior to seeing your physician.* ***Take these forms with you for your physician to review and sign.*** *These forms* ***are*** *mandatory.*
- *Student Athletes, in addition to these health forms, please visit the athletic web site to download athletic health forms.* ***The athletic health forms should be taken to your physician to review and sign also.***

## General Information

***Examining Physician:***

- ***Please complete and sign pages 5 and 6*** *(Physician's Health Evaluation and Immunization Record).*
- ***Please review pages 2, 3 and 4*** *and* ***sign page 4*** *(Medical Health History Report ).*

Last name_____ First name_____ Preferred name_____ Middle name_____

Gender (circle) Male/Female Date of Birth_____ E-mail _____

Home Address (Street/P.O. Box )_____

City_____ State/Providence_____ ZIP/Postal Code_____ Country_____

Home Phone_____ Student's cell _____ Parent's cell_____

## Authorization for Treatment

☐ **I plan to participate in intercollegiate athletics** Sport: _____

I hereby authorize Geneva College nursing and medical personnel to give and /or provide for medical and minor surgical care to (myself/my son/my daughter) upon (my/his/her) request and to arrange for such care as is necessary in the event of an emergency.

**Student signature** (if over age 18)_____ Date_____

**Parent / Guardian** (if under age 18)_____ Date_____

## Emergency Contact Information

Relationship to Student_____

Parent/Guardian/Person to contact in case of emergency Phone number Work/Cell phone number

Alternate emergency contact Relationship Phone number

# Medical Health History Report

GENEVA COLLEGE

Please indicate if you have ever had any of the following health condition or concerns. Comment on all positive answers in the space provided. This information is to be completed prior to your physician's examination.

**Last name**_____ **First name**_____ **Middle name**_____

Gender (circle) M / F  Marital Status (circle) Single / Married / Other

Class you are entering (circle) Freshman / Sophomore / Junior / Senior

List colleges you have attended; include address and dates_____

_____

Are you a veteran? (circle) Yes / No  If yes, Branch_____ Length of Service_____

| **Family History** | Age | General Health | Occupation | Age of Death | Cause of Death |
|---|---|---|---|---|---|
| Father | | | | | |
| Mother | | | | | |
| Brothers | | | | | |
| | | | | | |
| | | | | | |
| Sisters | | | | | |
| | | | | | |
| | | | | | |

**Have any of your immediate blood relatives have had any of the following? (please list relationship to student)**

| | | | | | |
|---|---|---|---|---|---|
| Alcoholism | Yes/No | _____ | High cholesterol | Yes/No | _____ |
| Anemia | Yes/No | _____ | High blood pressure | Yes/No | _____ |
| Asthma, Hay fever | Yes/No | _____ | Kidney disease | Yes/No | _____ |
| Arthritis | Yes/No | _____ | Migraine headaches | Yes/No | _____ |
| Cancer | Yes/No | _____ | Stomach Disease | Yes/No | _____ |
| Diabetes | Yes/No | _____ | Tuberculosis | Yes/No | _____ |
| Epilepsy, Convulsions | Yes/No | _____ | Other? | Yes/No | _____ |
| Heart disease | Yes/No | _____ | None of the above | Yes | |

Do you plan to receive allergy shots while at Geneva College? (circle) Yes / No

Do you currently live, or have lived, outside of the United States? (circle) Yes / No

If yes, where and when_____

Are you currently receiving treatment for any condition? (circle) Yes / No

If yes, please explain_____

# Medical Health History Report

GENEVA COLLEGE

Please indicate if you have ever had any of the following health condition or concerns. Comment on all positive answers in the space provided. This information is to be completed prior to your physician's examination.

**Last name**_____ **First name**_____ **Middle name**_____

| | Yes/No | Comments | | Yes/No | Comments |
|---|---|---|---|---|---|
| **ALLERGIES TO:** | | | Insomnia | | |
| Medications (list) | | | Irritable bowel syndrome | | |
| Environmental | | | Jaundice | | |
| Other | | | Joint injury/disease | | |
| Albumin/Sugar in urine | | | Kidney stones | | |
| Anemia | | | Knee injury/trick knee | | |
| Anxiety | | | Lyme disease | | |
| Asthma | | | Malaria | | |
| Arthritis | | | Measles /German Measles | | |
| Back problem/injury | | | Migraine headaches | | |
| Bleeding trait | | | Mumps | | |
| Blood pressure/ HIGH | | | Obesity | | |
| Blood pressure/ LOW | | | Palpitations (heart) | | |
| Bronchitis | | | Peptic/duodenal ulcer | | |
| Cancer | | | Pneumonia | | |
| Chicken pox | | | Psychiatric condition | | |
| Chronic cough | | | Rheumatic fever* | | |
| Chronic fatigue | | | Treatment* | | |
| Crohn's disease | | | Scarlet fever | | |
| Depression | | | Seizure | | |
| Diarrhea | | | Shortness of breath | | |
| Dizziness, fainting | | | Sinusitis | | |
| Diabetes | | | Skin condition | | |
| Ear, nose, throat trouble | | | Strep throat | | |
| Eating disorder* | | | Stomach/intestinal trouble | | |
| Treatment* | | | Substance use (alcohol/drug)* | | |
| Eye condition / injury | | | Tobacco use* | | |
| Fracture: location | | | Treatment* | | |
| Gallbladder / gallstones | | | Surgery for:_____ | | |
| Hay fever | | | Thyroid condition | | |
| Headache (recurrent) | | | Tuberculosis | | |
| Heart murmur | | | Weakness, paralysis | | |
| Hernia / rupture | | | Weight gain/loss | | |
| Hearing loss | | | **FEMALE:** | | |
| Head injury w/loss | | | Irregular periods | | |
| Hepatitis (give types) | | | Painful / severe cramps | | |
| High cholesterol | | | Other (list):_____ | | |
| Hypoglycemia | | | Other (list):_____ | | |
| Infectious mononucleosis | | | Other (list):_____ | | |

## Medical Health History Report

GENEVA COLLEGE

Please indicate if you have ever had any of the following health condition or concerns. Comment on in the space provided. This information is to be completed prior to your physician's examination.

**Last name**_____ **First name**_____ **Middle name**_____

A. Has your physical activity been restricted during the past 5 years? (circle) Yes / No Give reasons and durations.

B. Have you had difficulty with school, studies, or teacher? (circle) Yes / No Give details.

C. Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problem? (circle) Yes / No Give details and list all medications take for this condition.

D. Have you had any illness, injury or been hospitalized other than already noted? (circle) Yes / No Give details.

E. Have you consulted or been treated by clinics, physician, healers, or other practitioners within the past 5 years, other than routine checkups? (circle) Yes / No

F. Have you been rejected or discharged from military service because of physical, emotional or other reasons? (circle ) Yes / No Give details.

G. Do you have any question regarding your health, family history, or other matters, such as pre-martial counseling, which you would like to discuss now with a staff member of Health Services? (circle) Yes / No

H. Are you taking any medication or drugs? (circle) Yes / No

I. Do you have any dietary problems necessitating special diets? (circle) Yes / No

Remarks or additional information:

By signing this document, I agree that I have disclosed all information concerning physical and /or psychological conditions for which I have been diagnosed or treated.

**Student signature**_____ Date _____

**Physician's signature** _____ Date _____

ACCEPT THE CHALLENGE™ **(continued)**

## Physician's Health Evaluation

This form is to be completed for all New Students by a physician, nurse practitioner or physician's assistant. This student has been accepted for Admission and the information supplied will not affect the student's status: it will be used only as a background for providing health care as necessary. The information obtained is strictly for the use of the Health Services

**Last name**_____ **First name**_____ **Middle name**_____

☐ **I plan to participate in intercollegiate athletics.** **Sport:** _____

Height_____ Weight_____ BP_____ Pulse_____ Tuberculin Skin Test (circle) Pos / Neg

Urinalysis: Sugar_____ Albumin_____ Micro_____ Hemoglobin (if indicated) _____gms/%

Are there abnormalities of the following systems?

| | **Yes / No** | **Explanation/Findings** |
|---|---|---|
| Skin | _____ | _____ |
| Eyes | _____ | _____ |
| Vision: corrected/uncorrected | _____ | _____ |
| Ears, nose, throat | _____ | _____ |
| Respiratory | _____ | _____ |
| Cardiovascular | _____ | _____ |
| Gastrointestinal | _____ | _____ |
| Hernia | _____ | _____ |
| Genito-urinary | _____ | _____ |
| Musculoskeletal | _____ | _____ |
| Metabolic/Endocrine | _____ | _____ |
| Neuropsychiatric | _____ | _____ |

Is there loss or serious impaired function of any paired organ? (circle) Yes / No

Do you have any recommendations regarding the care of this student? (circle) Yes / No Please explain.

Is the patient now under treatment for any medical or emotional conditions? (circle) Yes / No

**Normal examination-cleared for intercollegiate athletics (circle) Yes / No**

**Physician's Signature**_____ Date_____

**Print Physician's full name**_____

Street Address_____

City_____ State_____ ZIP/Postal Code_____

*This recommended form has been approved by the Liaison Committee of the American College Health Association and the American Medical Association and approved by the American College Health Association.*

## Immunization Record

This form is to be completed for all New Students by a physician, nurse practitioner or physician's assistant. This student has been accepted for Admission and the information supplied will not affect the student's status: it will be used only as a background for providing health care as necessary. The information obtained is strictly for the use of the Health Services

**Last name**_____ **First name**_____ **Middle name**_____

| Immunizations | Completed | Date(s) of immunizations |
|---|---|---|
| Tetanus Toxoid (booster) | Yes / No | _____ |
| D.P.T. / Tetanus-Diphtheria (3 basic and 3 boosters) | Yes / No | _____ _____ _____ _____ _____ _____ |
| M.M.R. / Measles, Mumps & Rubella (2 doses) | Yes / No | _____ _____ |
| Polio (3 doses—live or Salk) | Yes / No | _____ _____ _____ |
| Hepatitis B (Recommended) | Yes / No | _____ _____ _____ |
| Hepatitis A | Yes / No | _____ _____ |
| Meningococcal Conjugate (groups A/C/Y/W-135) | Yes / No | _____ |
| Varicella (Chicken Pox) | Yes / No | _____ _____ |
| Gardasil (HPV) | Yes / No | _____ _____ _____ |
| Other immunizations: _____ | Yes / No | _____ _____ _____ _____ _____ _____ |
| Other immunizations: _____ | Yes / No | _____ _____ _____ _____ _____ _____ |

## Exemptions

*Only the following exemptions will be accepted:*

- Students born before January 1, 1957
- Medical Contraindications: A written, signed and dated statement from a physician must be provided citing the medical condition that contraindicates immunization, the expected duration of the exemption and the specific vaccine(s) being exempted.
- Religious exemption: A statement written, signed and dated by the student (or parent/guardian if the student is a minor) describing his/her objection to immunization based on religious tenets or practices. Philosophical objections will not be accepted.

Physician's Signature_____ Date_____

Print Physician's full name_____

Street Address_____

City_____ State_____ ZIP/Postal Code_____

## Meningococcal Vaccine Information

GENEVA COLLEGE

**Last name**_____ **First name**_____ **Middle name**_____

A message from Connie Erwin R.N., C Health Services Director, Geneva College

As the health service director at Geneva College, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and a **Pennsylvania law requiring all college resident student to either be vaccinated for meningitis or to sign a waiver from stating their reasons for not receiving the vaccination.** This Senate bill 955 was signed into law on June 28, 2002 and became effective as of August 28, 2002.

**Therefore, you must**: 1) Notify your primary care physician or local health department and arrange to receive the immunization prior to arriving to campus, or 2) Choose **NOT** to be immunized for religious or other reasons. You must sign and return the waiver stating that you understand the risks of meningitis but choose not to be immunized. Either proof of immunization , a prepaid order, or the competed waiver must be submitted to the Office of Admissions **prior** to moving into any Geneva College Housing.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the tissues surround the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Cases of meningitis among teens and young adults 15 to 24 years of age, (the age of most college students) have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives. Between 100 and 125 meningitis cases occur on college campuses and as many as 15 students will die from the disease.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States types A, C, Y and W-135. These types account for nearly two thirds of meningitis cases among college students.

I encourage you to learn more abut meningitis and the vaccine. For more information, please feel free to contact your local health department and/or consult your physician. You can also find information about the disease at www.cdc.gov/nip or www.cdc.gov/ncidod/dbmd/diseaseinfo/meningococcal_g.htm.

## Meningococcal Waiver

In accordance with the state of Pennsylvania's *College and University Student Vaccination Act*, Geneva College is providing you with this form, which must be completed prior to moving into a residence hall. Under this law, all college resident students must either be vaccinated for meningitis or sign a waiver form stating their reasons for not receiving the vaccination.

Please check the option you have chosen:

1. _____ I have received the Meningococcal Conjugate vaccine prior to arriving on campus. I have provided written documentation of my immunization to the Office of Admissions. This documentation is listed on the Physician Health Evaluation.
2. _____ I have been advised by Geneva College of the risks of meningococcal disease and I have reviewed the information provided to me. I am choosing NOT to be vaccinated for the following reason(s): _____
_____
_____

**Student signature**_____ Date_____

If you are UNDER the age of 18 at the time of signing this form, your parent or guardian's printed name and signature is required.

Print_____ Signature_____ Date_____