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, 2014
Spring Semester Deadline: December 15, 2014

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 page 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_____ Email _____

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

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					

Please list any mediations you are currently taking.

Name Medicine	Dosage

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

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

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 _____

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_____