Thaddeus Stevens College of Technology

Student Health and Counseling

750 E. King Street - Brenner Hall - Lancaster, PA 17602

717-299-7769 – meshey@stevenscollege.edu

717-391-3561 (fax)

Student ID:_____ **Major:**_____

MEDICAL RECORDS

Last Name | First Name | Middle Initial | Date of Birth

Home Address | City | State | Zip | Home Phone Number

Social Security Number | email address

Biological Sex □ Male □ Female | Gender Identity_____

IN CASE OF EMERGENCY, NOTIFY:

Name | Relationship

Home Address | City | State | Zip | Home Phone Number/Cell Phone

Work Address | City | State | Zip | Work Phone Number

HISTORY

Acne	□ Current	□ Past	□ Never	Gonorrhea	□ Current	□ Past	□ Never
ADD/ADHD	□ Current	□ Past	□ Never	Gout	□ Current	□ Past	□ Never
AIDS, ARC, + HIV	□ Current	□ Past	□ Never	Hay Fever	□ Current	□ Past	□ Never
Alcohol Problem	□ Current	□ Past	□ Never	Knee Injury	□ Current	□ Past	□ Never
Anemia	□ Current	□ Past	□ Never	Hearing Loss	□ Current	□ Past	□ Never
Anxiety D/o	□ Current	□ Past	□ Never	Heart Problems	□ Current	□ Past	□ Never
Asthma	□ Current	□ Past	□ Never	Specify_____			
Back Problems	□ Current	□ Past	□ Never	Heart Murmur	□ Current	□ Past	□ Never
Bladder Infection	□ Current	□ Past	□ Never	Hepatitis	□ Current	□ Past	□ Never
Bleeding Trait/	□ Current	□ Past	□ Never	Herpes	□ Current	□ Past	□ Never
sickle cell				Hypertension	□ Current	□ Past	□ Never
Bronchitis	□ Current	□ Past	□ Never	Hypoglycemia (low blood sugar)	□ Current	□ Past	□ Never
Cancer (location)	□ Current	□ Past	□ Never	Infectious Mononucleosis	□ Current	□ Past	□ Never
_____				Irritable Bowel Disease	□ Current	□ Past	□ Never
Chlamydia	□ Current	□ Past	□ Never	Kidney Infections/stones	□ Current	□ Past	□ Never
Colitis	□ Current	□ Past	□ Never	Learning Disability	□ Current	□ Past	□ Never
Concussion	□ Current	□ Past	□ Never	Migraine H/A, Vascular H/A, Tension H/A	□ Current	□ Past	□ Never
Depression	□ Current	□ Past	□ Never	COVID-19 (positive test results)	□ Current	□ Past	□ Never
Diabetes	□ Current	□ Past	□ Never	Ovarian Cyst	□ Current	□ Past	□ Never
Drug Dependent	□ Current	□ Past	□ Never	Peptic Ulcer	□ Current	□ Past	□ Never
Eating D/O	□ Current	□ Past	□ Never	Phlebitis	□ Current	□ Past	□ Never
Eczema	□ Current	□ Past	□ Never	Pneumonia	□ Current	□ Past	□ Never
Emotional/	□ Current	□ Past	□ Never	Rheumatic Fever	□ Current	□ Past	□ Never
mental illness, specify_____				Rheumatoid Arthritis	□ Current	□ Past	□ Never
Epilepsy/seizures	□ Current	□ Past	□ Never	Sinus Problem (chronic)	□ Current	□ Past	□ Never
Eye Problem	□ Current	□ Past	□ Never	Streptococcal Pharyngitis (strep throat)	□ Current	□ Past	□ Never
Specify_____				Suicide Attempt	□ Current	□ Past	□ Never
Fainting	□ Current	□ Past	□ Never	Syphilis	□ Current	□ Past	□ Never
Specify_____				Thyroid Problem	□ Current	□ Past	□ Never
Gallbladder D/O	□ Current	□ Past	□ Never	Tuberculosis	□ Current	□ Past	□ Never

Other Problems not listed (specify) _____
Injuries _____
Surgeries _____
Hospitalizations _____

Dietary Needs:_____

Smoking Status: □ Yes □ No # packs per day_____

Have you traveled outside the U.S. in the past year? □ Yes □ No Where:_____

Mental Health History:

Have you ever received psychiatric counseling	□ Yes (Date:_____)	□ No	□ Currently
Have you ever been hospitalized for psychiatric care?	□ Yes (Date:_____)	□ No	
Have you ever been treated for an eating d/o?	□ Yes (Date:_____)	□ No	□ Currently
Have you ever been treated for alcohol dependency?	□ Yes (Date:_____)	□ No	□ Currently
Have you ever been treated for drug dependency?	□ Yes (Date:_____)	□ No	□ Currently

List all current prescription medications:

Medication Name/dosage	Prescribing Provider	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies? □ Yes □ No

If "yes" please list:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you received allergy shots? □ Yes □ No

Family History

	Age	Status of Health	Occupation	If deceased, age & cause of death
Mother				
Father				
Siblings				

Are you adopted? □ Yes □ No

You are invited to discuss your answers or any other health related issues with the Student Health Services professional staff.

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within Student Health Services.

Applicants Signature **Date**

PHYSICAL EXAM

To be completed by Physician:

Thaddeus Stevens College of Technology
750 E. King Street – Brenner Hall - Lancaster, PA 17603
717-299-7769 meshey@stevenscolleg.edu
717-391-3561 (fax)

_____

Last Name First Name Middle Initial

BP_____Heart Rate_____Height (in.)_____Weight (lbs)_____

Examination Findings (Describe fully. Use additional sheets if necessary)

	NL	ABN	Findings (describe)		NL	ABN	Findings (describe)
General Appearance	□	□	_____	Neck	□	□	_____
Skin	□	□	_____	Chest	□	□	_____
Head	□	□	_____	Heart	□	□	_____
Eyes	□	□	_____	Abdomen	□	□	_____
Nose/Sinus	□	□	_____	Extremities	□	□	_____
Mouth	□	□	_____	Neuro	□	□	_____

General Comments_____
_____
_____

Recommendations for physical activity:
Including physical education, athletic activities, sports, etc : □ Unlimited □ Limited
Explain_____
_____

Is the patient now under treatment for any medical or emotional condition? □ Yes □ No
Explain_____
_____

_____
Practitioner's signature Phone Number

_____
Print Last Name Date

_____
Address City State Zip

AUTHORIZATION FOR TREATMENT OF MINORS

If the student has not yet reached her/his 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent or legal guardian is required.

I hereby grant permission to TSCT to proceed with any needed medical, mental health, or minor injuries treatment for the above named student. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the medical provider to contact me in the most expeditious manner possible. If said provider is unable to communicate with me, the treatment necessary for the best interest of the above named student will be given.

Parent/legal guardian signature:_____ **Date**_____

Printed Name:_____ **Relationship to student**_____

Home Phone Number:_____ **Work Phone Number:**_____

STUDENT IMMUNIZATION RECORD

Thaddeus Stevens College
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717-299-7769 meshey@stevenscollege.edu
717-391-3561 (fax)

_____
Last Name First Name Middle Initial

_____ **M F**
Date of Birth Biological sex (circle)

MANDATORY IMMUNIZATIONS for Thaddeus Stevens College of Technology

To be completed and signed by a health care provider. (Dates must include month, day & year)

REQUIRED IMMUNIZATIONS: Birthdate 1982 or later

M.M.R (Measles, Mumps, Rubella) **OR** **M.M.R. Titer** (Measles, Mumps, Rubella

Option 1
Dose 1 – Immunized at 1 yr or after
_____/_____/_____

Dose 2 – At least 4 weeks after dose 1
_____/_____/_____

Option 2
Lab Report of titer_____
Copy of report must be attached

Tetanus – Diphtheria (TD booster within last 10 years)
TD _____/_____/_____ or Tdap _____/_____/_____

COVID Vaccine: Circle: Moderna / Pfizer/ Johnson & Johnson
Date:_____/_____/_____
COVID Booster: Type_____ Date:____/_____/_____

COVID Waiver
I choose to waive the COVID vaccine
Signature: _____Date:_____

Meningococcal Vaccine Information

For individuals 18 years or older:
I am 18 years of age or older, I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of the meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Pennsylvania law requires an individual enrolled in an institution of higher education in Pennsylvania who resides on campus in student housing to receive vaccination against meningococcal disease unless the individual signs a waiver.

Meningococcal Waiver
I choose to waive the meningococcal vaccine.

_____
Signature of student (parent if under 18)

Date _____/_____/_____

If vaccine has not been received, a meningococcal waiver must be signed by student/parent

or

Meningococcal Vaccine
MCV(Menactra/Menveo/Menomune)

Date _____/_____/_____

Booster
(if initial dose was given before 16th birthday)
Date _____/_____/_____

Bexsero/Trumenba (type B)

Date _____/_____/_____

RECOMMENDED IMMUNIZATIONS:

Hepatitis B
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

Varicella
History of Disease (year)_____
or
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

Other:_____
_____

Practitioner's Signature:_____ **Print last name:**_____**Date:**_____
Address:_____**City:**_____**State:**_____**Zip:**_____**Phone #**_____

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Student Name

Date of Birth

HEALTH INSURANE COMPANY

Name

Policy Holder

Policy No. Group No.

Insurance company address City State Zip

Insurance company phone number

Copy of insurance card must be attached.