

# HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY (Side 2)

**Unanswered questions or incomplete blanks will require the form to be returned.**

Examining Physician: This student has been accepted. Please review and complete.

Name: Last		First		M.I.		(Circle One) Gender: M F	
Height:	Weight:	B/P:	Pulse:		Resp:		
Vision OS OD		Glasses/Contacts:		Colorblind: Yes No			
Hearing AS AD				Hearing Aids: Yes No			
Urine DIP	Glucose	Protein	Hgb./Hct (if indicated)				

**Describe fully, use extra sheet, if needed.**

Does patient have a history of:	Yes	No	Explanation	Does patient or blood relation have a history of:	Yes	No	Explanation
HIV/AIDS				Asthma or Hay Fever			
Injuries				Surgeries			
Head Injury w/loss of consciousness				Alcohol or Drug			
Loss or serious impairment of organs				Mental or Emotional Disorder			
Menstrual Disorder				Suicide Attempt			
Tobacco Use				Migraine H.A.			
Eating Disorder				Hypertension			
STD				Convulsions or Epilepsy			
Mono				Cancer			
Hepatitis				Diabetes			
Attention Deficit				Irritable Bowel			
Cystitis-recurrent				Sinusitis-Chronic			
Ovarian Cyst				Polycystic Ovary Disease			
Tuberculosis				Heart Disease or Murmur			

**Physical Exam: Are there any abnormalities of the following: Describe fully.**

Skin	Heart
Lymph Nodes	Abdomen
HEENT	Genital-urinary
Lungs	Musculoskeletal
Breast	Neuro

**Immunization Record – Please review and update if needed (all areas marked with an asterisk (\*) are REQUIRED)**

**\*Tuberculosis (TB) Screening Test – Required only of persons at high risk for TB** as defined by the Centers for Disease Control (foreign born persons, persons with compromised immune systems, close contacts of infectious TB cases, etc). **PPD (Mantoux) must be administered within the past 6 months.** \_\_\_ No, I am not at high risk for TB. \_\_\_ Yes, I am at high risk for TB as defined by Centers for Disease Control.

Date: \_\_\_\_\_ Result (must include mm induration): \_\_\_\_\_ If results ≥ 5 mm induration, the following is **REQUIRED**:

Chest X-Ray **within the past 6 months**: Date: \_\_\_\_\_ Chest X-Ray Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

-OR- Documentation of INH Therapy: Date Begin: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**Exception:** The Pennsylvania Department of Education requires that all Education majors provide a negative TB result.

Hepatitis B #1 date: \_\_\_\_\_ Hepatitis B #2 date: \_\_\_\_\_ Hepatitis B #3 date: \_\_\_\_\_

-OR- Positive Hepatitis B titre date: \_\_\_\_\_ **\*Tetanus date:** \_\_\_\_\_

**\*MMR#1 date:** \_\_\_\_\_ **\*MMRR#2 date:** \_\_\_\_\_ -OR- MMR titre date \_\_\_\_\_

Meningitis date: \_\_\_\_\_ Gardasil date: \_\_\_\_\_

**\*Varicella** (chickenpox disease): \_\_\_\_\_ -OR- Vaccine date: #1 \_\_\_\_\_, #2 \_\_\_\_\_ -OR- Positive titer date: \_\_\_\_\_

Allergies to medicine and type of reaction:

Other allergies: food, insects, latex, etc.:

Current Medications and dosages:

Provider's Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Signature: \_\_\_\_\_

Exam Date: \_\_\_\_\_

**HEALTH EVALUATION REPORT FOR MANSFIELD UNIVERSITY (Side 1)**

**STUDENT: Please complete Side 1 of form and have a physician complete Side 2. Once both sides are complete, return it to:**

**Student Affairs Office  
323 Alumni  
Mansfield University  
Mansfield, PA 16933**

Name:		Last	First	MI	Maiden	Social Security #	
Full Address:		Box/Apt.	Street/Road		City	State	Zip Code
Date of Birth:		Gender: M F		Home Phone: ( )		Major:	
Next of Kin:		Last	First	MI	Relationship:	Home Phone # ( )	Work Phone # ( )
Address:		Street		City	State	Zip Code	
Country of Citizenship?		Are you a veteran?		If yes, Branch:		If yes, Length of Service:	
<p><b>Please complete the following information to aid in treating you should an accident occur or uncovered service is needed while attending Mansfield University</b></p>							
INSURANCE INFORMATION REQUIRED (OR COPY OF INSURANCE CARD, FRONT AND BACK, MAY BE ATTACHED)							
Name of Policyholder:		Last	First	MI	Policyholder's Social Security #	Policyholder's Date of Birth:	
Name of Policyholder's Employer:							
Employer's Address:		Street		City	State	Zip Code	
Name of Insurance Company:							
Insurance Co. Address:		Street		City	State	Zip Code	
Phone # of member services:				Effective date of card:		Group #:	
ID#				(circle one) RX Plan: Yes No		(circle one) HMO: Yes No	
Preauthorization Phone #:		(Inpatient: )			(Outpatient: )		
Primary Care Provider:		Last	First	MI	Phone #: ( )		

(IT IS THE RESPONSIBILITY OF THE STUDENT OR PARENT TO NOTIFY US OF ANY CHANGE IN INSURANCE COVERAGE).

The information on this form is strictly for the use of the health services and will not be released to anyone without your knowledge and consent.

(-OVER-)