

CARLOW

U N I V E R S I T Y

Authorization for Release of Medical Information of Official Interoffice Communication.

I, the undersigned, do hereby authorize _____ ,
to release medical records regarding my past medical history and treatments to:

Carla Bergamasco RN, MSN
Carlow University
Health Services
3333 Fifth Avenue
Pittsburgh, PA 15213

P: 412.578.6174
F: 412.578.6468
E: crbergamasco@carlow.edu

Print Name of Student/Patient

Signature of Student/Patient

Date

Last Four Numbers of Social Security

Witness

For more information or questions, please call 412.578.6174.

TO BE COMPLETED BY STUDENT

STUDENT'S LAST NAME		FIRST NAME		MIDDLE	
ADDRESS WHILE ATTENDING THE UNIVERSITY (NO. AND STREET)					
PHONE WHILE ATTENDING THE UNIVERSITY (AREA CODE AND NO.)		BIRTH DATE (MO/DAY/YR)	MARITAL STATUS		SEX
			<input type="radio"/> Single <input type="radio"/> Married		<input type="radio"/> Male <input type="radio"/> Female
PERMANENT MAILING ADDRESS (NO. AND STREET)		CITY	STATE		ZIP CODE
PHONE (AREA CODE AND NO.)					
PERSON TO BE NOTIFIED IN AN EMERGENCY		Last name	First name	Middle	RELATIONSHIP
ADDRESS (IF DIFFERENT FROM PERMANENT ADDRESS)					PHONE (AREA CODE AND NO.)
NAME OF FAMILY OR PERSONAL PHYSICIAN					PHONE (AREA CODE AND NO.)
ADDRESS (NO. AND STREET)		CITY		STATE	ZIP CODE

FAMILY HISTORY

	AGE	STATE OF HEALTH	OCCUPATION	AGE OF DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHERS					
SISTERS					

REQUIRED HEALTH INSURANCE INFORMATION

Please photocopy the front and back of medical insurance card and prescription plan and attach. Report any changes in insurance. (All full-time and part-time undergraduate students attending Carlow University are required to have insurance while in attendance at the University. Health insurance may be purchased through the University; please see Health Services Web site for details).

PERSONAL HISTORY: PLEASE ANSWER ALL QUESTIONS.

Y N Have you had? <input type="radio"/> <input type="radio"/> Mononucleosis <input type="radio"/> <input type="radio"/> Hepatitis <input type="radio"/> <input type="radio"/> Chickenpox <input type="radio"/> <input type="radio"/> Gum or Tooth Trouble <input type="radio"/> <input type="radio"/> Sinusitis <input type="radio"/> <input type="radio"/> Eye Trouble <input type="radio"/> <input type="radio"/> Ear Problem <input type="radio"/> <input type="radio"/> Nose Problem <input type="radio"/> <input type="radio"/> Throat Problem <input type="radio"/> <input type="radio"/> Diabetes <input type="radio"/> <input type="radio"/> Convulsions <input type="radio"/> <input type="radio"/> Eczema <input type="radio"/> <input type="radio"/> Head Injury with Unconsciousness <input type="radio"/> <input type="radio"/> Neck Injury <input type="radio"/> <input type="radio"/> Thyroid <input type="radio"/> <input type="radio"/> Insomnia	Y N Have you had? <input type="radio"/> <input type="radio"/> Frequent Anxiety <input type="radio"/> <input type="radio"/> Frequent Depression <input type="radio"/> <input type="radio"/> Frequent Headaches <input type="radio"/> <input type="radio"/> Worry or Nervousness <input type="radio"/> <input type="radio"/> Hayfever <input type="radio"/> <input type="radio"/> Bronchitis <input type="radio"/> <input type="radio"/> Pneumonia <input type="radio"/> <input type="radio"/> T.B. <input type="radio"/> <input type="radio"/> Shortness of Breath <input type="radio"/> <input type="radio"/> Asthma <input type="radio"/> <input type="radio"/> Chest Pain <input type="radio"/> <input type="radio"/> Chronic Cough <input type="radio"/> <input type="radio"/> Back Problems <input type="radio"/> <input type="radio"/> Disease or Injury of Joints <input type="radio"/> <input type="radio"/> Hearing Difficulty <input type="radio"/> <input type="radio"/> Palpitations (Heart)	Y N Have you had? <input type="radio"/> <input type="radio"/> High BP <input type="radio"/> <input type="radio"/> Low BP <input type="radio"/> <input type="radio"/> Rheumatic Fever <input type="radio"/> <input type="radio"/> Heart Murmur <input type="radio"/> <input type="radio"/> Tumor, Cancer, Cyst <input type="radio"/> <input type="radio"/> Jaundice <input type="radio"/> <input type="radio"/> Gall Bladder Trouble <input type="radio"/> <input type="radio"/> Intestinal Trouble <input type="radio"/> <input type="radio"/> Stomach Trouble <input type="radio"/> <input type="radio"/> Recent Weight Gain <input type="radio"/> <input type="radio"/> Recent Weight Loss <input type="radio"/> <input type="radio"/> Eating Disorder <input type="radio"/> <input type="radio"/> Weakness, Paralysis <input type="radio"/> <input type="radio"/> Dizziness or Fainting <input type="radio"/> <input type="radio"/> Kidney Infection <input type="radio"/> <input type="radio"/> Recurrent Diarrhea	Y N Have you had? <input type="radio"/> <input type="radio"/> Recurrent Constipation <input type="radio"/> <input type="radio"/> Rupture, Hernia <input type="radio"/> <input type="radio"/> Environmental allergies <input type="radio"/> <input type="radio"/> Substance abuse <input type="radio"/> <input type="radio"/> Sexually Transmitted Disease FEMALES ONLY <input type="radio"/> <input type="radio"/> Irregular Periods <input type="radio"/> <input type="radio"/> Severe Cramps <input type="radio"/> <input type="radio"/> Excessive Flow
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IF YOU ARE CURRENTLY EXPERIENCING ANY OF THE ABOVE CONDITIONS, PLEASE CIRCLE THE CONDITION ON THE ABOVE CHART.

1. Please list any allergies and the reaction you experienced when exposed to that agent.

Agent _____ Reaction _____

Agent _____ Reaction _____

Agent _____ Reaction _____

2. Please list any medications you are currently taking.

3. Have you ever received or are you currently receiving treatment or counseling for a nervous condition, personality or character disorder, or emotional problem?

4. Please list any dietary or activity restrictions. _____

5. Do you use tobacco products? Yes ____ No ____ How long? _____ How much? _____

6. Do you use alcohol? Yes ____ No ____ How long? _____ How much? _____

7. Do you use recreational drugs? Yes ____ No ____ How long? _____ How much? _____

8. Have you ever been, or are you currently in an abusive relationship or situation, or are you in danger of being in one?

Yes ____ No ____ Please explain _____

9. Please list surgeries or hospitalizations you have had for treatment of any illnesses or conditions, and give the date.

Reason _____ Date _____

Reason _____ Date _____

Reason _____ Date _____

10. Is there any additional information, or do you have any concerns regarding your physical, emotional, psychological, social, or spiritual well-being?

IMMUNIZATION RECORD (TO BE COMPLETED BY HEALTH CARE PROVIDER)

		Date	Date	Date
REQUIRED VACCINATIONS FOR ALL INCOMING TRADITIONAL-AGE STUDENTS (FIRST-YEAR AND TRANSFER)	Measles, Mumps, Rubella (MMR) * Please note two dose requirement if born after 1957.			
ADDITIONAL REQUIREMENTS FOR RESIDENCE HALL STUDENTS	Meningococcal Vaccine (required by Pennsylvania law for students living on campus)			
	Hepatitis B series (three doses)			
RECOMMENDED VACCINATIONS FOR ALL STUDENTS	Varicella (chickenpox) or date of disease			
	Tetnus, Diptheria, Pertussis (Tetanus Booster within last 10 years)			
	Polio (OPV, IPV)			
	Hepatitis A vaccine			
	Influenza (especially nursing and education majors)			
	HPV (Human Papillomavirus, females 13-26) three doses			
	Other			
ADDITIONAL REQUIREMENTS FOR INTERNATIONAL STUDENTS	Tuberculin Skin Test (PPD) within 1 year of enrollment			
	Chest X-ray (required if skin test is positive)			

HEALTH CARE PROVIDER COMPLETING IMMUNIZATION RECORD:

Name _____ Telephone number _____

Signature _____ Date _____

WHY VACCINATE?

Measles

Measles is a highly contagious virus that can be spread by coming into contact with an infected person or the infected person's saliva through coughing and sneezing. It can cause serious illness such as pneumonia and encephalitis (inflammation of the brain). Two doses of vaccine provide lifelong protection. The vaccine can be administered alone or as part of the combination Measles, Mumps, Rubella (MMR) shot.

Mumps

Mumps is mainly a disease of younger children, but about 15 percent of reported cases occur among teens and adults. Mumps can cause deafness, encephalitis, meningitis, and rarely, sterility. Mumps vaccine can be administered as part of the MMR shot.

Rubella

Rubella (German measles) is caused by a virus that is spread by contact with infected people or articles that have been used. Symptoms can include rash, muscle pain, low-grade fever, and swelling in the neck. Rubella is especially dangerous for the fetus during the first three months of pregnancy. The pregnant woman may miscarry or the baby may be born with birth defects. Rubella is routinely administered as part of the MMR shot or may be given as a single-component vaccine.

Hepatitis B

Hepatitis B is a serious liver disease caused by a virus. The virus can be spread by coming into contact with the blood or other bodily fluids of an infected person. Hepatitis B virus can cause inflammation of the liver, which can lead to serious illness, liver cancer, and liver failure. Immunity is achieved by receiving a series of three injections of vaccine over a six-month period.

Meningitis

Although meningitis is rare, it is potentially fatal when it strikes. *Meningococcal* meningitis is a bacterial infection that causes inflammation of the membranes surrounding the brain and spinal cord. The infection can lead to permanent disabilities, such as hearing loss and brain damage. College students living in residence halls are at increased risk for developing the infection. *Meningococcal* bacteria are transmitted through air droplets and direct contact with persons already infected with the disease. This can be through coughing, kissing, sneezing, or sharing items like utensils, cigarettes, or drinking glasses. Symptoms of *Meningococcal* meningitis often resemble those of the flu. These symptoms include high fever, rash, vomiting, severe headache, neck stiffness, lethargy, nausea, and sensitivity to light. Pennsylvania State Law requires this vaccine for all college/university students residing on campus.

Tdap (Adacel)

Pertussis has become more prevalent in the U.S. over the last 20 years, especially among adolescents and adults. Pertussis can be spread easily which makes the infection difficult to control once it is established in the community. The use of antibiotics does not significantly alter the course of infection once you acquire the cough related to Pertussis. One-time use of Tdap is recommended for adults between the ages of 19 and 64.

For more information on immunizations, please visit: www.immunize.org or www.cdc.gov/ncidod/dbmd/diseaseinfo.

MEDICAL EXEMPTION (CHECK ALL THAT APPLY)

I have been advised by my physician that I should not receive vaccination for: Measles Mumps Rubella Hepatitis B Meningitis

Due to the following condition: _____

I understand that I am subject to exclusion from Carlow University's campus in the event of a disease for which I am not vaccinated. I have read and understand the information about these diseases and the risks involved.

Name of physician _____ Office telephone number _____

RELIGIOUS EXEMPTION

I affirm that immunization is in conflict with my religious beliefs. I understand the risks and am choosing not to be vaccinated at this time. I understand that I am subject to exclusion from Carlow University's campus in the event of an outbreak of any of the above diseases for which I am not vaccinated.

SIGNATURE OF STUDENT

SIGNATURE OF PASTOR

DATE

By submission of this Health History Immunization Documentation form, I am attesting to the fact that the above information pertains to my personal health history and is true and correct.

CARLOW

UNIVERSITY

HEALTH HISTORY

IMMUNIZATION DOCUMENTATION FORM

Carlow University requires all incoming, full-time, traditional-age students (first-year and transfer) to complete and return a Health History/Immunization Documentation Form. The immunization portion must be signed by a health care provider. The entire form must be completed and submitted prior to the first day of class. Resident students will not be permitted to move into the resident halls if this form has not been submitted. Student athletes are required to complete and submit both this form as well as the health forms that they receive from the Department of Athletics.

CONFIDENTIALITY

The information on this form will be used, if necessary, solely as an aid to provide health care while you are a student at Carlow University. Except in emergencies, or when required by law, no medical information will be given to parents or guardians without the written or oral permission of the student. No medical information will be shared with Carlow professors or staff without the written consent of the student. Medical information will be released to other health professionals, potential employers, insurance companies, etc. only with the written consent of the student.

ACCOMMODATIONS

Students who require special accommodations should contact Jackie Smith, Director of Disability Services, 412.578.6257.

CONSENT FOR CARE

I, _____, voluntarily give my consent to Carlow University Health Services, and such medical provider and/or assistant to the Carlow University Health Services as they may deem necessary to provide medical services to me. I am authorizing Carlow University Health Services to treat me during my enrollment as a Carlow University student or until I withdraw my consent in writing.

I understand that there is no fee to see the nurse, but there is a \$10 fee to see the physician that will be billed directly to my student account, and I am financially responsible for that fee. I also understand that I am financially responsible for all charges incurred for any and all services received outside of Carlow University Health Services, including ambulance fees, lab fees, etc., if necessary.

I hereby certify that I have read fully the above authorization and that no guarantee has been made as to the results that may be obtained from the provision of a medical service.

Signature _____ Date _____

Parent or guardian signature (if student under 18 yr.) _____ Date _____

Please check: Resident Commuter **Start term:** Fall Spring Summer Year _____

MAIL TO:
Carlow University Health Services
3333 Fifth Avenue
Pittsburgh, Pennsylvania 15213
(Return envelope enclosed for your convenience.)

DIRECTOR:
Carla Bergamasco RN, MSN
P: 412.578.6174
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E: crbergamasco@carlow.edu

LOCATION:
4th floor, Frances Warde Hall