**RETURN THIS DOCUMENT**
to the Student Health Center, 109 University Square, Erie, PA 16541

GANNON
UNIVERSITY

# Health Examination Form

**Students will not be eligible for services provided by the Student Health Center until this document is completed in its entirety and returned.**

The Health Examination Form includes personal data, family history, insurance information, an immunization record and personal history to be completed by the student. The last page of this document, the medical examination form, must be completed by a physician. We suggest completing this during the summer and returning it to our office in the enclosed envelope. **A photocopy should be made for your records before returning the document**.

Before a student is permitted into campus housing, they must submit a Health Examination Form with the date of their meningitis vaccine indicated or sign a Mandatory Meningitis Immunization/Exemption Form stating a reason for a medical or religious exemption. Verification of the date of the meningitis vaccine, either noted on the Health Examination Form or on the Immunization/Exemption Form MUST be turned in to the Student Health Center.

In the meantime, if you have any questions, feel free to contact us at 814-871-7622, or visit **www.gannon.edu/health**.

*These documents contain confidential health records and will not be shared with any other office at Gannon University.*

(F) FRESHMEN STUDENTS

(T) TRANSFER STUDENTS

(C) COMMUTER STUDENTS

# Student Information

Name *(Last, First, Middle Initial)* | Cell Phone | Date of Birth | ❑ Male ❑ Female

Home Address | City | State | ZIP

**Emergency Contact**

Name | Relationship | Phone

Father's Name | Mother's Name

**Family Physician**

Name | Address | Phone

**Class Standing:** Freshman Sophomore Junior Senior Graduate

Academic Major | University Sport

# Family History

| Family Member | Age | Condition of Health | Nature of Illness | Cause of Death | Occupation |
|---|---|---|---|---|---|
| **Self** | | | | | |
| **Father** | | | | | |
| **Mother** | | | | | |
| **Brother(s)** | | | | | |
| **Sister(s)** | | | | | |

# Insurance Information

You may attach a photocopy of the front and back of insurance card instead of copying the information below.

**Insurance Provider**

Name | Phone

Policy I.D. Number | Group Number

Address | City | State | ZIP

**Policy Holder**

Name | Address

## Personal History

List any medicine, food or environmental substances to which you are allergic:

List any medications you are now taking (including birth control pills):

List any hospitalizations or conditions you feel would be important to your care in the student health services office:
(Please use additional sheet if needed.)

## Immunization Record

You may attach a photocopy instead of copying the information below.

| Vaccine | Doses (M/D/Y) | | | Booster and Dates | |
|---|---|---|---|---|---|
| **Tetanus and Diphtheria** | | | | | |
| **Hepatitis B** | | | | | |
| **MMR** | | | | | |
| **Polio** | | | | | |
| **Meningitis*** | | | | | |
| **Varicella** | | | | | |
| **HPV** | | | | | |
| **Most Current PPD** | Date Applied | Date Read | | Result | |

**State law mandates all students living in University housing be informed of the risk factors and dangers of meningococcal disease and receive the vaccine or waive off for medical/religious or other reasons.*

## Consent to Care

I hereby authorize and direct Gannon University to furnish a physician or physicians of their choice to render such medical or surgical treatment that I might need in case of illness or injury, including hospitalization and referrals where indicated. No guarantees have been made to me about the outcome of this care. I agree to be responsible for any expense in connection with the aforesaid, where my insurance policy does not provide for payment of the same.

By signing below, I attest the above information provided is true and accurate to the best of my knowledge.

Signature of Student Date

Parent Signature (if under 18) Date

# Confidential Medical Examination

TO BE COMPLETED BY A PHYSICIAN

**To the examining physician:** please review the student's history and complete the physician's form. Please comment on all positive answers. This student has elected to enroll. **The information supplied will not affect his or her status; it will be used only as a background for providing health care, if this is necessary.** This information is strictly for use in the Gannon University Student Health Center.

_____ ❑ Male ❑ Female

Name *(Last, First, Middle Initial)* Date of Birth

Height _____ Weight_____

Blood Pressure _____ / _____ Pulse _____

List drug allergies:

_____

_____

_____

| | No | Yes |
|---|---|---|
| **Skin** | | |
| **Eyes** | | |
| **Ears/Hearing** | | |
| **Nose** | | |
| **Throat** | | |
| **Respiratory** | | |
| **Cardiovascular** | | |
| **Musculoskeletal** | | |
| **Gastrointestinal** | | |
| **Metabolic/Endocrine** | | |
| **Neuropsychiatric** | | |

Are there any abnormalities to the following systems?
If yes, describe fully: (please use additional sheet if needed)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please note any physical or psychological conditions and/or medication prescribed:

_____

_____

_____

*Note: Please complete immunization record on previous page.*

**Heath Care Provider**

_____

Signature Print Last Name Date

_____

Address City State ZIP