Millersville University
HEALTH SERVICES

Witmer Building
4 McCollough Street
P.O. BOX 1002
Millersville, PA 17551
717-871-5250 • FAX: 717-871-7926

MU ID: _____ Name: _____ Date of Birth: _____

Student Cell Phone # _____ Preferred Name: _____

Gender at Birth _____ Pronouns: _____

Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Number: _____ Relation: _____

FAMILY MEDICAL HISTORY

	YES	NO	RELATION
Diabetes			
Epilepsy/Seizures			
Hypertension			
Cancer *(Specify: _____)*			
Mental Health *(Specify: _____)*			
Sickle Cell Disease			
Thyroid Disease			
Sudden cardiac death before age of 50			

PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	YES	NO	COMMENTS
ADD/ADHD			
Alcoholism/Drug Abuse			
Asthma			
Autism Spectrum Disorder			
Cancer			
Concussion/Head Injury			
Diabetes			
Gynecological Concerns (endometriosis, PCOS)			
Hearing Loss			
Heart Murmur			
High Blood Pressure ***(hypertension)***			
Insomnia			
Learning Disability			
Mental Health (specify diagnosis)			
Migraine Headaches			
Renal ***(kidney)*** Disease			
Seizures			
Thyroid Disease			
Other:			

SOCIAL HISTORY

Alcohol Use			
Food Insecurity			
Smoking			

Patient Name: _____ Date of Birth: _____

PHYSICAL EXAMINATION (TO BE COMPLETED BY A MEDICAL PROVIDER)

TO THE EXAMINING HEALTHCARE PROVIDER: Please review the student's health history and complete this form. The information supplied will be used as a background for providing any necessary health care, and for identifying any need for accommodation to facilitate the student's academic success. This information will be handled in accordance with all applicable law.

Date of Exam: _____ BP: _____ HR: _____ HT: _____ WT: _____

VISION: OD _____ OS _____ OU _____ (☐ Corrected/ ☐ Uncorrected)

	Normal	Abnormal	COMMENTS
General Health			
Skin			
Ears			
Eyes			
Neck (include thyroid exam)			
Lungs			
Heart			
Abdomen			
Back			
Extremities			
Neurological Exam			

Medical Summary (note problems or suggestions for care):_____

_____

_____

_____

_____

ALLERGIES & MEDICATIONS

ALLERGY/REACTION	MEDICATIONS (dose, frequency)
☐ NO KNOWN ALLERGIES	

Healthcare Provider Name (please print/stamp): _____

Address: _____ City:_____

State: _____ ZIP: _____ Signature: _____ MD/DO/CRNP Date:_____

Patient Name: _____ Date of Birth: _____

IMMUNIZATIONS/TUBERCULOSIS SCREENING:

1. Are you experiencing any possible symptoms of TB: unexplained weight loss, fevers >1 week, night sweats, persistent cough >3 weeks, cough productive of bloody sputum?

☐ **YES** ☐ **NO**

2. Do you have any risk factors for TB infection: close contact with known case of TB, use of illegal IV drugs, HIV infection, healthcare worker, resident/employee in nursing home/homeless shelter/correctional facility

☐ **YES** ☐ **NO**

3. Were you born in or traveled in the past 5 years (greater than 2 weeks) to any of the areas defined by the World Health Organization and the CDC as a region of high prevalence of TB? (see below)

☐ **YES** ☐ **NO**

Angola, Bangladesh, Brazil, China, Democratic People's Republic of Korea, Democratic Republic of the Congo, Ethiopia, India, Indonesia, Kenya, Mozambique, Myanmar, Nigeria, Pakistan, Philippines, Russian Federation, South Africa, Thailand, United Republic of Tanzania, Vietnam, Cambodia, Central African Republic, Lesotho, Liberia, Namibia, Papua New Guinea, Sierra Leone, Zambia, Zimbabwe

If you answered YES to any of the questions above, then you are required to submit a negative PPD result (Mantoux), CXR, or IGRA results (QuantiFERON or T-SPOT). (Please attach results.)

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED:

- MMR (Measles, Mumps, Rubella) – 2 doses or titer
- Tetanus-Diphtheria-Pertussis (Tdap)
- Meningococcal (Meningitis, MCV4, Menveo, Menactra)

THE FOLLOWING IMMUNIZATIONS ARE RECOMMENDED:

- Varicella (Chicken pox) – 2 doses
- Hepatitis B – 3 doses
- HPV (Human Papillomavirus – Cervarix, Gardasil, Gardasil 9)
- COVID-19
- Meningococcal (MenB, Bexsero, Trumenba)
- Hepatitis A – 2 doses

PLEASE ATTACH A COMPLETE COPY OF YOUR MOST UP-TO-DATE IMMUNIZATIONS

Meningococcal Vaccine/Waiver

Pennsylvania state law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unless the vaccination against meningococcal disease has been received. If a student chooses not to be vaccinated, the student (parent/guardian of minors) must sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Meningococcal disease is rare but a potentially fatal infection that affects the lining of the brain and spinal cord. More detailed information can be found on the CDC website.

I, _____, reviewed the recommendation to receive the meningococcal vaccine. I am fully aware of the risks associated with meningococcal disease and of the availability and effectiveness of the vaccinations against the disease. By signing this waiver, I acknowledge the risks associated with declining the vaccine.

_____ Date: _____

Signature of student (guardian if student is not 18)

Immunization Waiver

By submitting this waiver, I acknowledge that I have been informed that I may be placing myself and others at risk of serious illness should I contract a disease that could have been prevented through proper vaccination. Students who claim exemption may be kept out of classes during the course of the disease outbreak if it is determined that such students are at risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes will vary depending on the disease. I hereby attest that I am declining immunization at this time for the below identified reason.

REASON (check one): ☐ Medical Reason _____ ☐ Religious/Philosophical

Signature: _____ Date: _____