**Thaddeus Stevens College of Technology** **Student Health and Counseling** Page 1

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

**Student ID:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Major:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 717-299-7769 – [meshey@stevenscollege.edu](mailto:meshey@stevenscollege.edu)

717-299-7769 (fax)

**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

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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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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**

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**PHYSICAL EXAM Thaddeus Stevens College of Technology**

**To be completed by Physician: 750 E. King Street – Brenner Hall - Lancaster, PA 17603**

**717-299-7769** [**meshey@stevenscolleg.edu**](mailto: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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Recommendations for physical activity:

Including physical education, athletic activities, sports, etc : □ Unlimited □ Limited

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**STUDENT IMMUNIZATION RECORD Thaddeus Stevens College**

**750 E. King Street – Brenner Hall - Lancaster, PA 17603**

**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 Option 2**

Dose 1 – Immunized at 1 yr or after Lab Report of titer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Copy of report must be attached

Dose 2 – At least 4 weeks after dose 1

\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

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**Tetanus – Diphtheria** (TD booster within last 10 years)

TD \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ or Tdap \_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**COVID Vaccine:** Circle: Moderna / Pfizer/ Johnson & Johnson **COVID Waiver**

Date:\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ I choose to waive the COVID vaccine

COVID Booster: Type\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_

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**Meningococcal Vaccine Information**

**For individuals 18 years or older: Meningococcal Waiver or Meningococcal Vaccine**

I am 18 years of age or older, I have received I choose to waive the meningococcal MCV(Menactra/Menveo/Menomune)

and reviewed the information provided on the vaccine.

risk of meningococcal disease and the Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

effectiveness and availability of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

meningococcal vaccine. I understand that Signature of student (parent if under 18) **Booster**

meningococcal disease is rare but life-threatening (if initial dose was given before 16th

illness. I understand that Pennsylvania law Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ birthday)

requires an individual enrolled in an Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

institution of higher education in Pennsylvania **If vaccine has not been received, a**

who resides on campus in student housing to receive **meningococcal waiver must be signed** **Bexsero/Trumenba** (type B)

vaccination against meningococcal disease unless **by student/parent**

the individual signs a waiver. Date \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_

**RECOMMENDED IMMUNIZATIONS:**

**Hepatitis B Varicella**

**Dose 1 \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ History of Disease (year)\_\_\_\_\_\_\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dose 2 \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ or**

**Dose 3 \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ Dose 1 \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dose 2 \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_**

**Practitioner’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print last name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Thaddeus Stevens College**

**750 E. King Street – Brenner Hall - Lancaster, PA 17603**

**717-299-7769 meshey@stevenscollege.edu**

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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.**