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MANDATORY

University of Pittsburgh at Johnstown Student Health Record

Please Return Completed Form To:

Student Health Services
 Student Union G-10
 University of Pittsburgh at Johnstown
 Johnstown, PA 15904
 Phone (814) 269-7110
 Fax (814) 269-2053

NO PHYSICIAN'S PHYSICAL REQUIRED

Please print in ink or type all entries.

Student	Last Name	First	M.I.	Entering/Current Status (Circle)			Transfer Student?	
				Fresh.	Soph.	Jr.	Sr.	Yes No
Home Address:		Street	City	State	Zip Code	Phone ()		
Student Cell Phone		Birthdate		Marital Status		Sex		
()				S () M () W () D ()		M () F ()		
In Case of Emergency Notify:	Last Name	First	M.I.	Relationship to Student				
Address of Emergency Person:	Street	City	State	Zip Code	Phone Home () Work ()			
Health Insurance Company								
			ID#	GROUP#				
Are you under a doctor's care for any health problems at present				Yes () No ()				
If yes,								
Doctor's Name:			Phone:					
Address _____								
Describe problem: _____								
Do you have any ALLERGIES to the following?								
<u>Yes</u>	<u>No</u>							
()	()	Medications - please list name of medication and type of reaction						

()	()	Circle all that apply:						
		Pollen	Ragweed	Grasses	Dust	Mold	Smoke	
()	()	Food Allergies - please list						

()	()	Others - please list						

Immunization Record

A **photocopy** of your immunization record is **required** and will complete documentation of this page.
Failure to comply will result in a hold on next term's registration.

MANDATORY

- A. **Measles/Mumps/Rubella (MMR)** (Two doses required.)
1. Dose 1 given at age 12-15 months or later.....#1____/____/____
 2. Dose 2 given at age 4-6 years or later, and at least one month after first dose#2____/____/____

RECOMMENDED

- B. **Tetanus-Diphtheria** (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.)
1. Primary Series of four doses with DTaP or DTP:
#1 ____/____/____ #2____/____/____ #3____/____/____ #4____/____/____
 2. Tetanus-Diphtheria(Td) booster within the last ten years.....____/____/____
- C. **Polio** (Primary series in childhood meets requirement; three primary series schedules are acceptable.)
Completed Primary Series Yes____ No____
Type: Oral____ Injection____ Booster ____/____/____
- D. **Varicella** (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets the requirement.)
1. History of Disease Yes____ No____
 2. Varicella antibody ____/____/____ Reactive____ Non-reactive____
 3. Immunization
 - a. Dose #1.....#1 ____/____/____
 - b. Dose#2, given at least one month after first dose.....#2 ____/____/____
- E. **Hepatitis B** (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)
1. Immunization
Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
- F. **Meningococcal** (One dose, preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease. Any undergraduate less than 25 years of age wishing to reduce their risk of disease can consider the vaccine.
Quadrivalent polysaccharide vaccine.....Date ____/____/____
- G. **Gardasil** (females) Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

Exemptions from Immunization

A student may be granted medical exemption from immunization based on a written statement from a physician, or his designee, that the immunization may be detrimental to the health of the student. A religious exemption from immunization may be granted based on a student's written objection to the immunization on religious grounds or on the basis of a strong moral or ethical conviction similar to a religious belief. However, if an outbreak of Measles, Mumps or Rubella occurs, students who do not provide proof of immunity to these diseases may be excluded from classes.

Self Evaluation of Lifestyle Factors and Mental Health

1. Body Basics :

What is your Height? _____

What is your Weight? _____

Do you have any identifying marks or scars, including tattoos? _____

If yes, please identify. _____

2. Tobacco Use :

Do you smoke cigarettes? _____

If yes, how many per day? _____

How long have you been a smoker? _____

Do you chew tobacco? _____

3. Alcohol Use :

How often do you drink alcohol?

not at all less than once a week

once a week 2 or 3 times per week

more than three times per week

What is your average alcohol consumption (number of shots, 8oz. beers or 6 oz. glasses of wine) per drinking occasion? _____

4. Mental Health/Stress :

Do you feel uptight or nervous much of the time? _____

Do you feel that you are unable to function effectively because of stress? _____

Have you ever considered/attempted suicide? _____

Have you ever received professional counseling for emotional or psychological problems? _____

Have you ever been prescribed any psychiatric medication or nerve pills? _____

Would you like advice or help regarding any of these problems? _____

Write a brief statement of your perception of your overall physical, mental, and emotional health. _____

This information which I have provided on this health form is complete and accurate, to the best of my knowledge.

Date

Student's Signature