UNIVERSITY OF PITTSBURGH AT TITUSVILLE
MANDATORY STUDENT HEALTH EVALUATION FORM
(Required only upon initial acceptance of full time status)

Completed health form MUST be returned to the address below:

University of Pittsburgh at Titusville
Health Center, Attn: Kim Roser, R.N.
508 E. Walnut Street
Titusville, PA 16354
FAX: 814-827-4450 PHONE: 814-827-4467
E-mail: kroser@pitt.edu

ALL students, residential or commuters, must complete a Health Form upon *initial* acceptance of full-time status.

TODAY'S DATE: _____________________

COMMUTER ________ **RESIDENT** ________

INSTRUCTIONS: **Entire form must be completed by the applicant. A physical exam is not required for entrance into the university.**

PLEASE PRINT OR TYPE

____
Last Name | First | Middle

____
Home Address: Street | City | State | Zip

____
Home Phone: Area Code and Number | Cell Phone: Area Code and Number

____
Date of Birth | Sex | Marital Status | Religion

____
Person to notify in case of emergency | Relationship to student

____
Address if different from above | Emergency Contact Number

INSURANCE INFORMATION

The University of Pittsburgh's policy requires that all students must produce proof of health insurance.

Please give the following information of insurance coverage below:

Insurance Company Name ____________________________________ Subscriber ____

Agreement # ____ Group # ____

Please enclose a photocopy front and back of your insurance card.

If you would need a referral by a Preferred Care Provider, (your physician) to see a physician in the U.P.T. area, please list:

Physician's Name____Phone______________________Fax_________________________

Address ____City ______________________State ________ Zip ____________

It is recommended that you check to see if your insurance will cover referrals outside your area. If not, it would be to your advantage to get a "guest membership" which will then permit you, if necessary, to see a physician in the campus area. If you do not currently have health insurance please contact me at the phone number or e-mail above.

PERSONAL HEALTH HISTORY

PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

1. Eye/Ear/Nose/Throat Problems
2. Thyroid problems
3. Tooth/gum disease
4. Diabetes
5. Abdominal pain/indigestion
6. Intestinal disorder
7. Blood diseases
8. Stroke
9. High blood pressure
10. Tuberculosis/positive skin test
11. Asthma/other respirator problems
12. Kidney problem/frequent urinary tract infection
13. Drug/alcohol addiction
14. Heart problems
15. Pelvic infection/sexually transmitted disease
16. Coronary artery disease
17. Epilepsy/seizures
18. Menstrual problems
19. Cancer
20. Skin problems
21. Surgery
22. Concussion
23. Gout/arthritis/rheumatic fever
24. Back problems
25. Liver problems, hepatitis
26. Eating Disorder/Anorexia/Bulimia
27. Digestive disorder
28. Physical/sexual assault
29. Migraine headaches
30. Mental Health (depression/anxiety)
31. Fainting episodes
32. Other ______________________

FAMILY HEALTH HISTORY

PLEASE CIRCLE	*RELATIONSHIP*
Diabetes	_________________
Epilepsy	_________________
High blood pressure	_________________
Heart Disease	_________________
Thyroid problem	_________________
Obesity	_________________
Alcohol/drug addiction	_________________
Cancer	_________________
Asthma/lung disease	_________________
Stroke	_________________
Mental disorder	_________________
Other_________________	_________________
_____________________	_________________
_____________________	_________________
_____________________	_________________

NAME: ____

1. Are you currently under a doctor's care for any health problems? ____

   Current Medications: ____

2. Do you have any physical handicap or limitations? ____
3. Allergies: Medication: ____________________ Environmental: ____________________ Food: ________________________

REQUIRED FOR ALL UNIVERSITY OF PITTSBURGH STUDENTS
(*STARRED ITEMS REQUIRED ONLY IF BORN IN 1957 OR LATER)
COPY OF IMMUNIZATIONS REQUIRED

1. *MMR (Measles, Mumps, Rubella) – 2 doses required: 1. ____/____/____ 2. ____/____/____

OR all of the following MUST be met:

***Measles (Rubeola)**

2 doses required: 1. ____/____/____ 2. ____/____/____ OR positive titer: ____/____/____

***Mumps**

1 dose required: 1. ____/____/____ OR positive titer: ____/____/____

***Rubella**

1 dose required: 1. ____/____/____ OR positive titer: ____/____/____

OR

1 current MMR 1. ____/____/____

REQUIRED FOR STUDENTS LIVING IN THE RESIDENT HALLS ONLY

2. Meningococcal Meningitis Vaccination (**If planning on receiving the vaccine before classes start, please sign the waiver NOW so we can complete the housing process as soon as possible**, then send vaccine verification when received.) _____/_____/_____

OR waiver MUST be signed

I am 18 years of age or older and have received and reviewed the meningitis information provided by the University and have chosen not to be vaccinated as of this date: __________________ ____

DATE SIGNATURE

My child is under 18 years of age and I have received and reviewed the meningitis information provided by the University and have chosen not to have my child vaccinated as of this date: _________________ ______________________________________

DATE GUARDIAN'S SIGNATURE

OTHER RECOMMENDED VACCINATIONS

Tetanus/Diphtheria:	1. ____/____/____	2. ____/____/____	3. ____/____/____	4. ____/____/____
Tetanus Booster:	____/____/____	OR	Tdap: ____/____/____	
Polio:	1. ____/____/____	2. ____/____/____	3. ____/____/____	4. ____/____/____
Hepatitis A/B:	1. ____/____/____	2. ____/____/____	3. ____/____/____	
HPV (Gardisil)	1. ____/____/____	2. ____/____/____	3. ____/____/____	
Varicella	1. ____/____/____	2. ____/____/____		