

GANNON UNIVERSITY
**HEALTH EXAMINATION
FORM**

GANNON
UNIVERSITY

Believe in the possibilities.

RETURN THIS PAGE

to Gannon Health Center 109 University Square, Erie, PA 16541 • Fax (814) 871-7736 • Email health@gannon.edu • QR Code for upload

Completion and submission of this document is required for use of Health services. The document must be complete and returned to the Gannon Health Center ONE MONTH PRIOR to the start of classes.

Your medical information will be stored as confidential medical information in the Gannon Health Center for no longer than seven years at which time it will be shredded.

Due to varying requirements, health forms for NCAA athletics, health science majors, and clinical rotations are above, beyond, and separate from this document. This document is not used to address those requirements.

Before a student is permitted to move into on-campus housing, they must provide proof of at least one dose of meningitis vaccination (MenACWY) - OR - complete and sign the Mandatory Meningitis Immunization/Waiver Form (pg. 4 of this document) if they are choosing not to receive one. One dose of MenACWY or a signed waiver is required by the state of PA to reside in university owned housing.

Prior to submitting to the Gannon Health Center, save a copy of this document for your files as this document is not retained indefinitely.

SUBMIT THE COMPLETED DOCUMENT VIA ANY OF THE FOLLOWING METHODS:

Hand deliver to:

Gannon Health Center
210 W. Sixth St., Erie, PA 16507

Mail hard copy to:

Gannon Health Center
109 University Square, Erie, PA 16541

Fax to: (814) 871-7736

Email to: health@gannon.edu



Scan to upload
with Gannon
network ID

STUDENT INFORMATION:

First Name _____ Middle Initial _____ Last Name _____

Male Female Prefer not to answer Other _____

Date of Birth _____ Cell # _____ Alt. # _____

HOME ADDRESS:

Street _____ Apt/House/PO Box # _____

City _____ State _____ Zip Code _____ Country _____

CLASSES AND SPORTS: (check all that apply)

ESL First Year Sophomore Junior Senior Graduate Transfer

Part Time Full Time Major: _____

Sport(s) / Club Sport(s): _____

HOUSING:

Online Commuter University-owned Housing On-Campus Resident/Residence Hall _____

EMERGENCY CONTACTS:

First and Last Name _____ Relationship _____ Phone Number _____

First and Last Name _____ Relationship _____ Phone Number _____

Physician Name _____ Phone Number _____

Office Name and Address: _____

INSURANCE: (upload or include a copy of front and back of card with this completed form) I have included an image of my insurance card.

Insurance Type/Name _____ Member ID _____

Group Number _____ Plan Number _____

Policy Holder Name _____ Relationship to Student _____

Policy Holder Date of Birth _____ Address _____

Phone and Address on Back of Card (where to file claims) _____

RETURN THIS PAGE

to Gannon Health Center 109 University Square, Erie, PA 16541 • Fax (814) 871-7736 • Email health@gannon.edu • QR Code for upload

ALLERGIES

I DO HAVE environmental / seasonal allergies (pollen, dust, cats, dogs, trees, flowers, mold, etc.)

List below medication, food, substance or chemical allergies (penicillin, sulfa, contrast dye, betadine, band-aid, latex, nickel, etc.)

| Allergen Name | Reaction Experienced | Severity (mild, medium, severe) |
|---------------|----------------------|---------------------------------|
| | | |
| | | |
| | | |

MEDICATIONS

List Daily Medications (include birth control: implants, patches, IUDs and injections; nasal sprays, daily allergy or heart burn medications, as-needed prescription medications such as inhalers) Add supplemental sheet if needed.

| Medication Name | Dosage (mg, mcg, ml) | Frequency (daily, twice daily, as needed, etc.) |
|-----------------|----------------------|---|
| | | |
| | | |
| | | |
| | | |

MEDICAL HISTORY

Neurological

- Migraines
- Concussion(s)
- Seizures
- Guillain Barre
- Multiple Sclerosis

Other: _____

Ears, Nose, Throat

- Deafness / Hearing Problem
- Tinnitus / Vertigo
- Difficulty Swallowing

Other: _____

Respiratory

- Asthma
- Tuberculosis
- Cystic Fibrosis
- History of Pneumonia
- History of Pulmonary Embolism

Other: _____

Cardiac

- POTs
- Syncope (fainting)
- Palpitations
- Heart Murmur
- High Blood Pressure

Other: _____

Gastrointestinal

- GERD / Heartburn
- IBS (irritable bowel syndrome)
- Celiac disease
- Crohn's / Ulcerative Colitis
- Chronic nausea, vomit, diarrhea

Other: _____

Musculoskeletal

- Lupus
- Rheumatoid arthritis
- Deformity / Amputation
- Paralysis
- Arthritis

Other: _____

Dermatologic

- Acne
- Alopecia (hair loss)
- Psoriasis
- Eczema
- Skin infections

Other: _____

Mental

- Anxiety / Depression
- ADD / ADHD
- Schizophrenia
- Bipolar
- Borderline Personality Disorder

Other: _____

Blood / Hematologic

- Anemia
- Thalassemia / Sickle Cell
- Leukemia
- Hemophilia / Factor 5
- DVT (blood clots)

Other: _____

Endocrine

- Thyroid
- Cushing's / Addison's
- Diabetes
- Pituitary
- PCOS

Other: _____

Eyes

- Vision or eye problems
- Glasses or contact lenses
- Eye injuries
- Blindness
- Color Blindness

Other: _____

Student's LAST Name

Student's FIRST Name

RETURN THIS PAGE

to Gannon Health Center 109 University Square, Erie, PA 16541 • Fax (814) 871-7736 • Email health@gannon.edu • QR Code for upload

FAMILY HISTORY

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

List any hospitalizations or conditions you feel would be important to your care in the Health Center; include any past surgical history: (please use additional sheet if needed)

VACCINATION HISTORY

If attaching a copy of your immunization/vaccination record, initial here _____

| VACCINE NAME | BRAND NAMES | DD/MM/YY | DD/MM/YY | DD/MM/YY | DD/MM/YY | DD/MM/YY |
|---|--|----------|----------|----------|----------|----------|
| Tetanus & Diphtheria (5 doses) | Daptacel, Infanrix, Dtap, Quadracel, Kinrix, Pentacel, Trihibit, Pediatrix, Tripedia | | | | | |
| Hepatitis B (3 doses) | Engerix-B, Hep B, HBV, Comvax, Pediarix, Recombivax-HB, Twinrix | | | | | |
| MMR (Measles, Mumps, Rubella) (2 doses) | MMR | | | | | |
| Polio (4 doses) | IPV, Pediatrix, Pentacel, Quadracel, Kinrix | | | | | |
| Meningitis ACWY (2-3 doses)* | MenACWY, Menactra, Menveo, Medquadfi | | | | | |
| Meningitis B (2-3 doses) | Trumemba, Bexsero | | | | | |
| Varicella (2 doses) | Varicella | | | | | |
| HPV (3 doses) | HPV | | | | | |
| COVID-19 | Vaccine: | | | | | |

*State law mandates all students living in university housing be informed of the risk factors and dangers of meningococcal disease and receive at least one dose of the MenACWY vaccine or waive off for medical/religious or other acceptable reasons. <https://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2002&sessInd=0&act=83>

TB TEST**

**Required for international students. Domestic students, please report here if obtained.

| Latest PPD test | | -OR- | Interferon Gamma Release Assay (IGRA) blood test | |
|--------------------|---------------------|------|--|--|
| Date Placed: _____ | Date Read: _____ | | Date of Test (DD/MM/YY): _____ | Specify Method (TB Gold, TSpot, other-please specify): _____ |
| Size MM: _____ | Neg. or Pos.: _____ | | Result: _____ | |

IF PPD OR IGRA TB TEST IS POSITIVE, A CHEST X-RAY IS REQUIRED

Date of chest x-ray (DD/MM/YY) _____ Result of x-ray: Normal Abnormal Medication given: _____

CONSENT TO CARE

I hereby authorize and direct Gannon University to furnish a health care provider of their choice to render such medical 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 _____

MANDATORY MENINGITIS IMMUNIZATION FORM / WAIVER

College students are at increased risk for meningitis, a potentially fatal bacterial infection. Individuals between the age of 18-24 who are attending college are at 3.5 x higher risk than their peers who are not attending college. This risk increases due to close living quarters when the student is staying in residence halls on campus.

The CDC, the American College Health Association, and the Immunization Action Coalition have advised that college students who have not yet been vaccinated for meningitis, learn more about risks versus benefits of vaccination against the disease. *Pennsylvania legislation requires meningitis vaccination with MenACWY for students living on campus or a signed declination / waiver after receiving information about the benefits of meningitis vaccination.*

What is meningococcal meningitis? Meningitis is rare, but can result in very severe symptoms, disability, and even death as quickly as within 24 hours. This illness causes inflammation of the lining surrounding the brain and spinal column (meninges). One out of five people infected will progress to serious and often permanent symptoms (hearing loss, seizures, brain damage, limb amputation, skin scarring). One in 10 people infected will die.

How is it spread? Meningococcal meningitis is spread through respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing, or sharing items like utensils, cigarettes, and drinks.

What are the symptoms? Symptoms of meningitis include a sudden onset of a high fever, severe headache, and stiff neck, which rapidly progress to rash, nausea, vomiting, lethargy, then confusion, seizures, shock, and death.

Who is at risk? Unvaccinated people, people from certain regions of the world, immune compromised people due to disease, lack of a spleen, chemotherapy, or immunosuppressant medications, very young age or very old age, and those people living in close quarters with others such as military bases and college campuses.

Can Meningitis be prevented? A safe and effective vaccine is available to protect against four of the five most common strains of the disease (MenACWY). The vaccine provides protection for approximately 3-5 years. This vaccine is a childhood vaccine typically received around age 11-12 y/o and again around age 16 y/o and occasionally with a third dose around age 18-19 y/o if the second dose was given before the 16th birthday (unless waived).

The MenB vaccine exists to protect against the Meningitis B strain. It provides immunity for about 2 years and protects against the meningitis strain most often seen in college students. This is not a childhood vaccine, which is likely the reason it is the most prevalent strain seen in this population (already protected due to MenACWY).

Adverse reactions to the meningitis vaccines are mild and infrequent, consisting mainly of redness at the injection site, low grade fever, headaches, nausea, and fatigue.

These vaccines do not prevent all strains of meningitis but help to prevent the most prevalent strains. Vaccines do not guarantee protection against illness, but significantly reduce the chance of infection or if infected, should significantly reduce the severity of any infection. **These vaccines will not protect against Viral Meningitis.**

For more information, refer to:CDC: <https://www.cdc.gov/meningococcal/index.html>Immunization Action Coalition: <https://www.immunize.org/catg.d/p4210.pdf>

For more information about how to receive a free MenACWY vaccine call the Erie County Department of Health at (814) 451-6700.

PLEASE CHECK THE STATEMENT(S) THAT APPLY TO YOU AND SIGN / DATE

N/A - Not living on campus Vaccination Received (Proof included in vaccination history)

I am **NOT** vaccinated for meningitis. I have read and understand the information regarding meningitis and prevention through vaccination. Currently, I choose to **DECLINE MENINGITIS VACCINATION**. I also understand that if there is an outbreak of meningitis on campus, for my safety and the safety of others, I will be required to vacate campus housing.

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

Student Name Printed_____
Student Signature_____
Date_____
Parent / Guardian Signature (if students is under 18 y/o)_____
Date

CONFIDENTIAL MEDICAL EXAMINATION

TO BE COMPLETED BY HEALTH CARE PROVIDER

To the examining provider: please review the student's history and complete this form. Please comment on all positive answers. This student has elected to enroll at Gannon University. **The information supplied will not affect the student's enrollment 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 Health Center.

Name (Last, First, Middle Initial)

Date of Birth

Height _____

Weight _____

Blood Pressure _____ / _____

Pulse _____

List Drug Allergies/Food Allergies:

| | No | Yes |
|-----------------------------|----|-----|
| Skin | | |
| Eyes | | |
| Ear, Nose, Throat (ENT) | | |
| Respiratory | | |
| Cardiovascular | | |
| Musculoskeletal | | |
| Blood/Hematologic | | |
| Genitourinary | | |
| Gastrointestinal | | |
| Metabolic/Endocrine | | |
| Neurological | | |
| Psychiatric/Mental Disorder | | |

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 (if activity is limited, please explain):

Note: Please complete immunization record on page 3 of this form and/or attach a copy of record.

HEALTH CARE PROVIDER

Signature Print Name and Credentials Date

Address City State Zip



Scan to upload completed form
with Gannon network ID.



Scan to upload completed form
with Gannon network ID.

Gannon University Health Center

109 University Square, Erie, PA 16541

Phone: (814) 871-7622 • Email: health@gannon.edu

GANNON
UNIVERSITY

Believe in the possibilities.