Arabic Language Institute of Philadelphia

HEALTH EXAMINATION REPORT

It is mandatory that all full-time students entering the Arabic Language Institute of Philadelphia (ALIPH) have a completed Health Examination Report on file, thus enabling the administrative staff to render optimum health care when needed.

In the past several years, outbreaks of vaccine-preventable diseases on college campuses throughout the United States have resulted in many lost school days, severe complications from the diseases, anxieties for students and their parents, and large expenditures of monies to contain these outbreaks. Compliance by each student with the pre-entrance immunization policy at the ALIPH protects the student and the staff of the institution.

All students are required to complete the health examination report prior to the beginning of classes in the initial term of full-time enrollment.

Pages 1, 2, and 3 should be completed by the student prior to being examined by the clinician. Pages 4 and 5 are for the clinician to complete.

Entering Term: Year _____ **Status:** □ Dorm Resident □ Off-Campus Commuter **Gender:** □ Male □ Female

Name Last First Middle Initial **ID # or Social Security #**

Birth Date **Birth Place** **Home Phone** **Cell Phone**

Permanent home address Street

City State Zip

Father's full name

Father's address Street

City State Zip

Guardian's full name

Local address Street

City State Zip

Mother's full name

Mother's address Street

City State Zip

Spouse's full name

IN CASE OF EMERGENCY NOTIFY *(Please Print)*

Full name Relationship

Address

Work Place Home Phone Cell Phone

IN THE EVENT OF SERIOUS ILLNESS OR INJURY, PARENTS OR GUARDIAN WILL BE NOTIFIED AT THE DISCRETION OF THE PROFESSIONAL STAFF.

Signature(s) Required: I certify that to the best of my knowledge that the information on this form is complete and correct.

Signature of the Student Date

Consent: I consent to medical treatment by the ALIPH Administrative Staff, including referral to medical facilities.

Signature of student (18 years old or older) Date

Consent for Minor (under 18 years of age):
I give my permission for medical treatment for my daughter/son if accident/illness should occur while she/he is a student at ALIPH. This would include referral to a local hospital which may result in her/his hospitalization, anesthesia, and surgery should it be necessary and I am unable to be reached.

Parent or guardian's name (please print) Relationship

Signature of parent or guardian Date

NAME: _____

Have you ever had or have you now any of the following: (Explain YES answers in the space provided on the next page)

Check each item	YES	NO	Check each item	YES	NO	Check each item	YES	NO
HEAD/NERVOUS SYSTEM			**HEART, LUNGS**			**PAST HISTORY**		
Headache			High cholesterol			Operations		
Seizures/convulsions			High blood pressure			Serious injury/accident		
Dizzy spells/fainting			Heart murmur			Emotional problem/treatment		
Insomnia			Palpitations			**OTHER**	**YES**	**NO**
Schizophrenia			Shortness of breath			Diabetes		
Depression			Chest pain			Malignant disease		
Nervousness/anxiety			Asthma/wheezing			Benign tumor		
Neuromuscular disorder			Chronic cough			Anorexia Nervosa		
EARS, EYES, NOSE, THROAT	**YES**	**NO**	Pneumonia			Bulimia		
Wear glasses/contact lenses			Bronchitis			Obesity		
Eye injury/disease			Do you drink alcohol/use drugs?			Sudden weight change—gain /loss		
Double vision			Do you smoke?			Hospitalization		
Deafness, hearing aid			Chest pain, dizziness or fainting with exercise			Hepatitis or jaundice		
Perforated eardrum			**DIGESTIVE**	**YES**	**NO**	Hemorrhoid trouble		
Repeated ear infections			Diarrhea, chronic/current			Need a special diet — what kind?		
Repeated nose bleeds			Colitis, ileitis			Other psychiatric condition		
Frequent sore throats			Irritable bowel syndrome			Immunocompromised state		
Tonsils/Adenoids removed			Gallstones			Other medical conditions		
Sinus trouble			**URINARY**	**YES**	**NO**	**INFECTIOUS DISEASE**	**YES**	**NO**
BLOOD	**YES**	**NO**	Frequent urination			Mononucleosis		
Anemia			Painful urination			Chicken Pox		
Easy Bruising			Blood in urine			Rheumatic fever		
Sickle cell trait or disease			Recurrent urinary infection			TB or positive skin test		
DENTAL	**YES**	**NO**	Kidney infection			Malaria		
Poor teeth/toothaches			Kidney stone			Whooping cough		
Bleeding gums			**BONES, JOINTS**	**YES**	**NO**	Meningitis		
Gum disease			Fractures, dislocations			Sexually transmitted disease		
Bridges/braces/plates			Painful joints			Other		
NECK	**YES**	**NO**	Knee problem			**SKIN/HAIR**	**YES**	**NO**
Swollen glands often			Paralysis/polio			Acne		
Thyroid problems/disease			Arthritis			Fungal infection		
ALLERGIES	**YES**	**NO**	Disc problem			Scabies		
Hay fever			Back problems			Other skin diseases		
Food allergy			Joint/back injury requiring treatment			Lice		
Medicine allergy								
Hives								

List medicines you are allergic to: _____

_____

List foods you are allergic to: _____

_____

NAME: _____

Explain YES answers from the chart on the previous page here:

Medicines, including over the counter medications, supplements, and herbs (list those now taking): _____

_____

_____

_____

Please note any past or present illness or conditions for which you are having or had medical care or treatment: _____

_____

_____

_____

_____

_____

_____

Other health problems: _____

_____

_____

_____

Are you missing any organs (eyes, kidney, testicles, etc.)? _____

_____

_____

_____

GYNECOLOGICAL HISTORY *(FOR FEMALES ONLY)*		**YES**	**NO**		**YES**	**NO**
Age of onset Menses:	Disabled by cramps			PMS		
Length of Cycle:	Irregular periods			Breast lumps		
Duration of flow – Days:	Bleeding between periods			Pregnancies		
Take contraceptive medications? (Y / N) Circle.	Vaginitis/discharge			Pelvic inflammatory disease		

Explanation for YES answers with date: _____

_____

_____

_____

_____

_____

NAME: _____

Medical Examination: Required within one year prior to admission

TO THE CLINICIAN: Please review the student's history and complete the Medical Examination Form. The information will be used only as a background for providing health care and will not be released without student consent.

Examination Date: _____

Wt. _____ **Ht.** _____ **BP** _____ **P** _____ **Vision:** W/o glasses _____ W/Glasses _____

Right 20/_____ Left 20/_____

SYSTEM	NORMAL (✓)	DESCRIBE IF ABNORMAL
Skin/Hair (fungal, scabies, lice, etc.)		
Ears		
Nose, throat, teeth, gingival		
Neck, thyroid		
Chest, breasts		
Lungs		
Heart (describe murmur, click, etc.)		
Abdomen, liver, spleen, kidneys		
Hernia		
Extremities, back, spine		
Lymphatic		
Neurological		
Psychological		

List all ALLERGIES (including medications, foods, insect venom, etc.): _____

Comment on type of reaction (i.e. rash, urticarial, anaphylaxis): _____

List all MEDICATIONS currently being taken: _____

Comment on special dietary requirements: _____

Status of student's physical restrictions: □ Unrestricted □ Restricted □ Full Restriction □ Partial Restriction

Comment: _____

Status of student's health: □ Excellent □ Good □ Poor **Comment:** _____

Past or current medical history: _____

_____

_____

_____

HEALTH CARE PROVIDER (Please print or use stamp)

_____ _____

Print Clinician's Name Last First **Phone Number** **Fax Number**

_____

Address Street City State Zip

_____

Clinician's Signature and Title

NAME: _____

IMMUNIZATION RECORD: Immunity is RECOMMENDED prior to registration.

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. (Dates must include month and year.)

	Month Day Year
A. TETANUS-DIPHTHERIA	
1. ☐ Completed primary series of tetanus diphtheria immunizations.....	_____/_____/_____
2. ☐ Tetanus-diphtheria booster required within the last 10 years.....	_____/_____/_____
3. ☐ Tetanus, diphtheria, pertussis.....	_____/_____/_____
B. MMR (MEASLES, MUMPS, RUBELLA)	
1. ☐ Dose 1 — Immunized at 12-15 months of age.....	_____/_____/_____
2. ☐ Dose 2 — Immunized at 4-6 years of age.....	_____/_____/_____
C. VARICELLA (CHICKEN POX)	
1. ☐ Hx of Disease ☐ Yes _____ Year	
2. ☐ Vaccination: Two required doses: Dose #1 _____ /_____ Month Year Dose #2 _____ /_____ Month Year	
D. TUBERCULOSIS — CHECK APPROPRIATE BOX	
History of BCG vaccine is not considered contraindication	
1. ☐ PPD (Mantoux) test within the past year or ☐ IGRA (Interferon-Gamma Release Assay)	
Give date and test results ☐ Positive ☐ Negative.....	_____/_____/_____
2. ☐ Positive PPD — Chest x-ray required.	
Give date and result of chest x-ray ☐ Positive ☐ Negative.....	_____/_____/_____
3. ☐ Treatment, if any:_____	
E. POLIO	
1. Completed primary series of polio immunizations.....	_____/_____/_____
Type of vaccine: ☐ Oral ☐ IPV	
Last Booster:.....	_____/_____/_____

F. HEPATITIS B

1. Dose #1 _____ /_____ Month Year Dose #2 _____ /_____ Month Year Dose #3 _____ /_____ Month Year

G. HEPATITIS A

1. Dose #1 _____ /_____ Month Year Dose #2 _____ /_____ Month Year

H. MENINGITIS VACCINATION (MCV4 Sero Groups A,C,Y and W135) _____ /_____ / _____ Month Day Year ☐ Menactra ☐ Other (name) _____

I. MENINGITIS/SERO GROUP B VACCINE _____ /_____ Month Year _____ /_____ Month Year _____ /_____ Month Year Note vaccine name: _____

(*Meningitis/Sero Group B Vaccine is recommended for commuters; but mandatory for dorm residents)

HEALTH CARE PROVIDER (Please print or use stamp)

_____ _____

Print Clinician's Name Last First **Phone Number** **Fax Number**

_____

Address Street City State Zip

_____

Clinician's Signature and Title

HIPAA RELEASE FORM

Return this completed form with Medical Forms.

Dear Student:

It is important that in the event you are taken to the hospital or other medical facility, the ALIPH Administrative Staff must be able to obtain your medical and/or psychiatric records. These records will be used only for your medical follow-up care.

Please Print

_____

Name First Middle Initial Last

_____

Date of Birth

_____

Student ID Number or Social Security Number

Permission to obtain information:

I authorize the Administrative Staff of ALIPH to obtain my medical and/or psychiatric record(s) in the event that I am seen in the emergency room or other off-campus medical facilities. The information provided to the Health Services Office shall remain strictly confidential, and shall not be relayed in any way to any individual or company without additional written authorization from me.

Signature(s) Required:

_____

Signature of the Student Date

Consent for Minor (under 18 years of age):

_____

Parent or guardian's name (please print) Relationship

_____

Signature of parent or guardian Date