LVPG Family Medicine–Muhlenberg College
- 2400 Chew Street, Allentown, PA 18104
- Tel: 484-664-3199 Fax: 484-664-3522

Please complete this health form packet in its entirety and upload this entire health form, the Consent for Treatment, Communication Preference, and your insurance card as a single file to: https://webxfer.lvh.com/form/studenthealth#/

Section 1: Demographic Information

Legal Name _____ Date of Birth _____

Preferred Name: _____ Pronouns: _____ Sex Assigned at Birth: _____ Gender Identity: _____

Home Address _____

Cell Phone Number:_____

Section 2: Emergency Contact(s)

Name _____

Relationship to Student_____

Contact Phone Number: _____

Name _____

Relationship to Student_____

Contact Phone Number: _____

Section 3: Health Insurance

Visits to LVPG Family Medicine–Muhlenberg College are billed to insurance.

Insurance Company Name: _____

Insurance Company Address: _____

Policy Holder/Subscriber Name _____ Policy Holder Date of Birth: _____

Policy or ID Number:_____ Group # _____

Preferred Lab for your insurance (please circle): Health Network Lab Quest LabCorp

□ **Insurance card copy (front and back) must be included when submitting your health form.**

Student Health Insurance Plan: All students must either enroll in or waive the Student Health Insurance Plan. Waiver and enrollment information is through the website: https://rcmdstudentbenefits.com/muhlenbergcollege/

□ **I have completed the student health insurance waiver or enrolled in the student health insurance on the above website.**

Name _____ Date of Birth _____

Section 4: Personal Medical History

Please check if you currently have or had a history of conditions listed below. Explain "yes" answers.

Yes	No	Condition	Explanation
		Neurologic: headaches. migraines, seizure, history of concussion, other	
		Lung Disease: asthma, recurrent bronchitis, pneumonia. tuberculosis. Other	
		Heart/Cardiovascular: high blood pressure, murmurs, congenital defects, POTS, syncope, other	
		Intestinal: Crohn's, ulcerative colitis, irritable bowel syndrome, peptic ulcer disease, gastroesophageal reflux, dietary sensitivities	
		Endocrine Disorder: thyroid conditions, diabetes, other	
		Hematologic: anemia, clotting disorder, sickle cell, other	
		Rheumatologic: systemic lupus erythematous, rheumatoid arthritis, other	
		High Cholesterol	
		Liver Disease: hepatitis, jaundice gallbladder disease, other	
		Orthopedic: joint or muscle conditions, arthritis, major injuries, other	
		ENT: recurrent sinus infections, recurrent strep throat, ear infections, hearing deficits, other.	
		Eye Conditions	
		GYN: menstrual disorder, ovarian cysts, polycystic ovarian syndrome, other	
		Testicular Conditions	
		Sexually Transmitted Infection	
		Anxiety, depression, bipolar disorder, obsessive compulsive other, other	
		Eating Disorder	
		Autism Spectrum Disorder	
		ADD/ADHD	
		Cancer	
		Congenital abnormalities	
		Other?	
		Previous Surgeries	

Section 5: Family History

Yes	No	Condition	Family Member
		Heart/ Cardiovascular Condition - Specify:	
		Lung Disease – Specify:	
		Diabetes– Specify:	
		Hypertension– Specify:	
		Thyroid Disease– Specify:	
		Blood Clots– Specify:	
		Cancer– Specify:	
		Anxiety, Depression, Bipolar, other mental health condition– Specify:	
		Other– Specify:	

Name:_____ Date of Birth:_____

Section 6: Current Medications

Please list all current medications, including prescribed, over the counter, birth control, supplements. Include medication name, dose, and how often you take it. Attach separate sheet if needed.

Section 7: Allergies

Are you allergic to any **MEDICATIONS**? _____. If yes, please specify medication name and reaction _____
_____

Are you allergic to any **FOOD**? _____. If yes, please specify food and reaction _____
_____

Note: We encourage you to also formally report your food allergy through the Special Dining Services Request process through the Office of Disability Services. This process will facilitate consultations and meetings with Dining Services staff.

Do you have any **ENVIRONMENTAL** allergies? _____. If yes, please specify and reaction _____
_____

Section 8: Meningococcal Disease and Vaccination Information

All students must read the information about meningococcal disease and vaccine information found on the Muhlenberg College Health Form website. Students should also read the CDC Vaccine Information Statements: Meningococcal B Vaccine VIS, Meningococcal ACWY Vaccine VIS

In 2002, Pennsylvania enacted the College and University Student Vaccination Act that requires all students who will reside in campus housing be educated about Meningitis and the benefits of vaccination. Students residing in college owned housing must provide documentation of vaccination for meningococcal A, C, Y, W-135 (Menactra, Menveo or MenQuadfi) or complete waivers declining the vaccines. We also recommend vaccination for Meningococcal serogroup B (Bexsero and Trumenba).

Meningococcal Disease and Vaccine Information: Student Attestation.
Please compete and sign one of the statements below:

□ I attest that I have received and read information regarding meningococcal disease and vaccination. I have provided documentation of receiving meningococcal meningococcal A, C, Y, W-135 (Menactra, Menveo or MenQuadfi) on my Immunization Record.
Student Signature _____ Date _____
-OR-
□ Waiver: I have read and understand the information provided regarding the risks of meningococcal disease and the availability and effectiveness of the vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe that I understand the risks associated with meningococcal disease and the availability and effectiveness of the vaccine required. Ho□wever, I am requesting exemption pursuant to the Pennsylvania College and University Student Vaccination Act, 35 P.S. § 633.1 et seq
Student Signature _____ Date _____
Parent Signature _____ Date _____
Parent Printed Name _____

Name:_____ Date of Birth:_____

Section 9: Create or Update your MyLVHN Chart online

To ensure a quick registration process, we encourage all students to have a "MyLVHN" chart. Please follow the steps below to update or create your MyLVHN chart.

Steps	Completed (Yes/No)
➢ Login to MyLVHN Students who already have a MyLVHN chart because they have accessed medical care previously by an LVHN provider do not need to create a new MyLVHN chart. If you have a MyChart account, login and proceed. If you do not have a MyChart account, create an account (Click "New user? Sign up now")	
➢ Add your Health Insurance information ○ Click on the three horizontal bars in upper left corner ("Your menu") ○ On the drop down menu, scroll down to "Insurance" ○ Click "Insurance Summary" ○ Click "Update Coverage" ○ Click "Add Coverage" on bottom of screen ○ Upload an image of your health insurance	
➢ Add your Personal Information ○ Click on the three horizontal bars in upper left corner ("Your menu") ○ On the drop down menu, scroll down to "Account Settings" ○ Click "Personal Information" ○ Complete the following sections: ○ Personal Information ○ Contact Information ○ Details about me ○ Family and Friends to contact in case of emergency	
➢ Complete your Communication Preferences Form ○ Click on the three horizontal bars in upper left corner ("Your menu") ○ In the search bar under "Your menu", search for "Communication Preferences" and complete	

Section 10: Complete other LVPG Forms

(links to these forms are on the Muhlenberg College Health Forms website)

	Completed (Yes/No)
➢ **Consent for Treatment Form** (all students must sign and parent/legal guardian must also sign if student is less than 18 years) **Medical Consent Authorization Minor** (parent/legal guardian must also sign if student is less than 18 years if student is less than 18 years) ➢ **Medical Information Communication Preference**	

PHYSICAL EXAM (to be completed by health care provider)

ALL STUDENTS: A physical exam is required within 12 months prior to the first day of class at Muhlenberg College.
VARSITY ATHLETES: A physical exam is required within 6 months prior to the start of fall practices at Muhlenberg College.
Physical Exam and Immunization Record will be disclosed to and used by LVPG Family Medicine – Muhlenberg College and Sports Medicine

Student's Legal Name:_____ **DOB:**_____ **Preferred Name:** _____
Sex assigned at birth:_____ **Gender Identity:**_____**Pronouns:**_____ **Athletes – Sport:** _____

Section I: Physical Exam (Required)

Exam Date: _____ **Height** _____ **Weight:** _____**BMI:** _____ **B/P :**_____ **Pulse:**_____
Pupils: ❑**Equal** ❑**Unequal Vision: R 20/** _____ **L20/** _____ **Corrected:** ❑Yes ❑No

	NORMAL	ABNORMAL FINDINGS (describe) or COMMENTS
Skin		
Eyes/Ears/Hearing/Nose/Throat		
Respiratory/ Lungs		
Cardiovascular: Heart rhythm ❑ Normal ❑Abnormal • Heart murmur ❑No ❑Yes If yes, specify: ❑ Systolic Murmur or ❑ Diastolic Murmur, Location_____ Grade (I-VI) _____ Does murmur increase with Valsalva? ❑ No ❑Yes • Pulses ❑ Normal ❑Abnormal. Any delay in femoral pulses? ❑ No ❑ Yes • Marfan Criterias (Chest deformities, long arms and legs, wrist/joint hyperflexibility, flat footedness, scoliosis, lens dislocation, high arched palate, etc): ❑ No ❑Yes Abnormal Findings or Comments:		
Abdomen		
Genitourinary/Testicles/ Hernia		
Musculoskeletal		
Neurologic		# of Concussions: _____
Emotional		

Section II: Health History (Required. All questions must be answered. Attach additional sheet, if needed)

- Take any **medications**? If yes, please list med, dose, frequency. **( )NO ( )YES** _____
- Any **allergies** (medicine, food, environmental)? **( )NO ( )YES**, explain_____
- History of **Anaphylaxis**? **( )NO ( )YES**, what was the trigger? _____ Carry an EpiPen or AuviQ? ( )NO ( )YES
- Have a loss or seriously impaired function of any paired organ? **( )NO ( )YES**, explain _____
- **Medical & Surgical History** (include treatment for any medical or psychologic condition) _____
  _____
- Any **general comments or recommendations** that may be important for the care of this student
  _____

Section III: Tuberculosis Risk Assessment (Required) #1 and #2 must be answered, If Yes, PPD or IGRA required.

1. **Does the student have signs or symptoms of active tuberculosis disease?** ( )NO ( )YES, explain_____
   If YES, proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.
2. **Is the student a member of a high-risk group, or ever had close contact with persons known or suspected to have active TB disease, or lived in/visited high-risk regions such as South America, Central America, Asia, parts of Europe, or Africa?** ( )NO ( )YES

***If Yes to #1 or #2 , IGRA or PPD (Mantoux) test required. Must complete below.**
Interferon Gamma Release Assay (IGRA) Date obtained:_____ Specify method: ☐QFT-GIT ☐T-Spot
Result: ☐ Positive ☐ Negative ☐ Indeterminant ☐Borderline (T-Spot only)

Tuberculin Skin Test (PPD) Date given (within the 6 months of college entrance) _____
Date Read _____Result: _____ (mm of induration) ☐ Positive ☐ Negative

CHEST X-RAY REQUIRED (if tuberculin skin test or IGRA is positive). X-Ray result: ☐ Normal ☐ Abnormal Date: _____
Treatment (Include treatment and dates)_____

Section IV - Varsity Athletes only: Varsity Sports Clearance (must include EKG and Sickle Cell Trait Results)

❑Cleared without restriction ❑Cleared with restriction. Specify:_____
❑Not Cleared. Include reason:_____

Section V – Required for all students; health care provider information

Date: _____ **Health Care Provider Signature:**_____
Health Care Provider Name_____**Telephone:** _____

IMMUNIZATION RECORD (to be completed by health care provider)

Please record dates (month/day/year) below and include a copy of vaccine records from student's medical provider.

Student's Legal Name: _____Preferred Name_____Date of Birth: _____

Required Immunizations	1st Dose	2nd Dose	3rd Dose	4th Dose
Hepatitis B 3 dose series is required. A blood test (titers) showing immunity is acceptable (upload lab result).				
Meningitis Quadrivalent (Serogroup A,C,Y,W-135) Circle type: Menactra, Menveo, or MenQuadfi Or Penbraya (serotypes A.B,C,W and Y) At least one dose must be on or after age 16 years				
MMR (Measles/Mumps/Rubella) Two doses required at least 28 days apart after 12 months of age. Or blood tests showing immunity is acceptable (upload lab report).				
Varicella (chicken pox) 2 doses required Or **History of having the disease on this date** Or a blood test (titer) showing immunity is acceptable (upload lab report).	 Date of disease			
Tdap Booster (Tetanus/Diphtheria/Pertussis) within past 10 years & on or after age 10 years				
Polio (OPV or IPV) Primary series of 3 or 4 doses in childhood				

Recommended Immunizations (not required)				
COVID-19 Primary Series and Booster(s) (Specify vaccine type in box)				
Hepatitis A				
HPV (Human Papillomavirus Vaccine)				
Influenza (annually)				
Meningitis Serogroup B Circle type: Bexsero or Trumemba (serogroup B) Or Penbraya (serogroup A, B, C, W, and Y)				

I certify that to the best of my knowledge the information on the Immunization Record is true and complete.

Date: _____ Healthcare Provider Signature:_____

Healthcare Provider Name: _____

Address: _____

Telephone:_____ Fax: _____

This page must be completed for

Varsity Athletes Only

Sickle Cell Trait Testing and EKG

Student's Legal Name:_____**Preferred Name:** _____**DOB:**_____

Health Care Provider: COMPLETE FOR VARSITY ATHLETES ONLY

Sickle Cell Trait Status Physician Verification

NCAA requires confirmation of sickle cell trait status for all Division III athletes.

❑I verify that the above named individual has been tested for sickle cell trait.

Date of Sickle Cell Trait Testing _____

Results: ❑Positive ❑Negative

❑Copy of lab results given to student.

Electrocardiogram

12-lead Resting ECG/EKG Required. Please attach interpretable copy of ECG.

❑Copy of ECG given to student.

Date: _____ Health Care Provider Signature:_____

Health Care Provider Name & Address: _____

Provider Telephone Number: _____ **Provider Fax:**_____