

DELAWARE VALLEY COLLEGE STUDENT HEALTH CENTER

SEND TO:

700 E. BUTLER AVENUE
DOYLESTOWN, PA 18901

E Mail: HealthCenter@delval.edu
Phone (215) 489-2252
FAX (215) 230-2990

IMPORTANT

This page to be signed by physician or verified by clinic stamp. Minimum immunization requirements listed on last page.

Please return all information 30 days prior to start of semester.

Please Print:

Student Cell Phone: _____ E mail address: _____

Last Name First Name Middle Name Social Security No. _____ H

Home Address(Number and Street) City State Zip

(Area Code)Telephone Number Date of Birth Sex (M or F) Marital Status(S, M, Other)

Health Insurance Address Policy No. I.D. No.

Emergency Contact Name & Relationship Emergency Contact Phone Number/ Cell Phone Number

Father Work Phone _____ Mother Work Phone _____

Cell Phone _____ Cell Phone _____

IMMUNIZATION DOCUMENTATION

VACCINE					
* DPT (Diphtheria, pertussis, tetanus) Initial Series of 3 Injections Required					
* Td (Tetanus-Diphtheria) booster within past 10 years					
* Polio, oral - Series of 3 doses					
* MMR #1					
* MMR #2					
Hepatitis B Vaccine					
* Meningitis Vaccine					
* Tuberculin Skin Test (PPD) (Required within 12 months prior to matriculation) The need for this testing will be determined by your physician, and will be made according to your risk factors.					
Date: _____ Results: (circle one) Positive or Negative					

Physician or Health Department certification that the above patient received the listed vaccine doses on the dates specified

Physician's Signature _____ Date _____

Physician's Name (Print or Type) _____

Office Address _____ Telephone _____

Health Dept./Clinic Stamp _____

City _____ State _____ Zip Code _____

PHYSICIAN EVALUATION

Name: _____

Check each item in the proper column.

Enter N. A. if not evaluated.

AREA OF EVALUATION	NORMAL	ABNORMAL	DETAILS OF EACH ABNORMALITY
Head, Neck, Face, and Scalp			
Nose and Sinuses			
Teeth and Gingiva			
Ears(perf. of drum, etc.)			
Eyes(lids, conjunctiva, etc.)			
Pupils and Ocular Motion			
Lungs, Chest, and Breasts			
Heart(include estimate of cardiac function)			
Vascular System(varicosities, etc.)			
Abdomen and Viscera(include hernia)			
Ano-rectal(pilonidal)			
Endocrine System			
G-U System			
Upper Extremities(strength, range of motion)			
Feet			
Lower Extremities(strength, range of motion)			
Spine, other Musculo-skeletal			
Skin and Lymphatics			
Neurologic			
Psychiatric(specify any personality deviations noted)			

Is this student able to participate in inter-collegiate sports? _____ Yes _____ No If "No" what activities are to be eliminated?

Is there (or has there been) evidence of anxiety or emotional instability? _____ If so indicate how this college may be of help.

After considering the history and physical examination, what is your professional opinion of the student's ability to meet the physical and emotional demands of college? _____

Do you recommend further investigation or treatment? _____

Height: _____ Weight: _____ B P : _____ Pulse: _____

Vision: _____ Urinalysis: _____
 R: _____ Glucose: _____

L: _____ Protein: _____

P H: _____

Physician's Signature _____

Date _____

ORTHOPEDIC HISTORY

Have you had, or do you now have: YES NO

Brain Concussion (head injury) ___ ___
 Neck Injury ___ ___
 Shoulder Injury ___ ___
 Back Injury or Scoliosis ___ ___
 Hand Injury ___ ___
 Knee Injury or recurrent pain ___ ___
 Ankle Injury or recurrent pain ___ ___
 Foot Problems ___ ___
 Joint Dislocations ___ ___
 Broken Bones ___ ___

If yes, name: _____

In which sports do you plan to participate?

___ CrossCountry ___ FieldHockey ___ Football
 ___ Soccer ___ Volleyball ___ Basketball
 ___ Wrestling ___ Cheerleading ___ Baseball
 ___ Golf ___ Softball ___ Track&Field
 Other: _____

Do you exercise continuously for at least 30 minutes, three or more times per week, i.e., swimming, running, walking, etc.? **yes** ___ **no** ___

Have you or are you currently taking any nutritional supplements? **yes** ___ **no** ___

If yes, name: _____

If you are involved in Inter-Collegiate sports, your health records are available to our Certified Athletic Trainers.

YOU ARE RESPONSIBLE FOR RETURNING THE DVC STUDENT HEALTH SERVICES FORM AND GETTING ANY NEEDED IMMUNIZATIONS IMMUNIZATION REQUIREMENTS FOR COLLEGE ENTRANTS

STUDENTS 17 YEARS OF AGE AND OLDER:
 3 DTP (Diphtheria, Tetanus, Pertussis) or Td(Tetanus-Diphtheria) doses as infant.
 1 Td (Tetanus-Diphtheria) booster within last 10 years
 3 Oral Polio doses
 2 MMR vaccinations
 Meningitis vaccine (State mandated for residents)
 A tuberculin skin test (PPD) is required within 12 mos. as determined by your physician.

WHERE CAN YOU OBTAIN AN ACCEPTABLE RECORD OF YOUR IMMUNIZATIONS?

1. **High School** - A copy of the immunization record by the High School from which you graduated may contain some, but not all of your immunization information. Please put your name and social security number on all records.
2. **Local Health Departments** - If primary immunizations were received at a local health department, a copy can be acquired from this source.
3. **Transfer Students** - If the college or university you attended previously, had immunization requirements, it is possible that these records will be acceptable proof of immunization. You will need to ask that facility to send your immunization record to you. You are responsible for returning the DVC Student Health Services form and getting any needed immunizations.