

**Frances M. Maguire College of Nursing and Health Professions  
MEDICAL HISTORY/PHYSICAL EXAMINATION RECORD**

**This form and requirements must be completed by August 31, 2025**

**Please read form in its entirety and do not leave any blanks. Make a copy and keep for your own records.  
Faxed forms will not be accepted.**

Complete and return all pages to:

Gwynedd Mercy University  
1325 Sumneytown Pike  
PO Box 901  
Gwynedd Valley, PA  
19437-0901  
Attn. Lorraine Quarles

Check all that apply:

athlete  
 resident  
 international student

**Student Information** (please print)

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

**Home Address**

\_\_\_\_\_  
City State Zip Code

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Are you an American citizen? \_\_\_\_\_ If not, please list citizenship \_\_\_\_\_

**Emergency Contact Information**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

I hereby give permission to the student health center practitioners or to a physician of their choice, to prescribe necessary medication and/or perform treatments or operations necessary in the best interest of my health. I understand that my parents or guardians will be notified of any serious illness or injury at my request.

\_\_\_\_\_  
Signature of student Date Signature of parent or guardian (if student is a minor) Date

**Health Insurance Information**

All full-time undergraduate and all international students are required to have health insurance. You will automatically be enrolled in the Student Health Insurance Plan unless you complete the following information and submit a waiver form. For more information contact Gwynedd Mercy University Health and Wellness Center at 215 646 7300, Ext. 306 or 445.

Name of Insurance Company \_\_\_\_\_ Customer Service Phone number \_\_\_\_\_

Group Number \_\_\_\_\_ Name of Policy Holder \_\_\_\_\_

Identification Number \_\_\_\_\_ Prescription Plan? Yes \_\_\_\_\_ No \_\_\_\_\_

**To the student:** You have been accepted to Gwynedd Mercy University. Information you provide will not be used to influence your situation at the University; it will be used solely as an aid to providing necessary health care while you are a student. This information is strictly for the use of Health Services and will not be released to anyone without your knowledge and consent.

**Report of Medical History**

**Please complete this before going to your health care provider for examination so your health care provider can acknowledge review of the information.**

**Family History**

	Age	State of Health	Cause of Death		Yes	No	Relationship
Father				Diabetes			
Mother				Heart Disease/Stroke/High Blood Pressure			
Siblings				Cancer			
				Asthma/Allergies			
				Tuberculosis			
				Alcohol/Drug Problem			
				Depression			

**Personal History - Please answer all questions - Please comment on all positive answers**

Have you had?	Yes	No	Comment
Chicken Pox			
Measles			
German Measles			
Mumps			
Mononucleosis			
More than 10 lb. weight gain or loss in past year			
Females: menstrual problems			

Have you had?	Yes	No	Comment
Head injury or concussion			
Epilepsy/seizures			
Migraines			
Anxiety or depression			
Sleep difficulty			
Eating disorder			
Alcohol/drug problem			
Learning disability			

**Personal History- Please answer all questions - Please comment on all positive answers.**

Have you had?	Yes	No	Comment
Dental problems			
Eye problems			
Ear, nose, throat problems			
Asthma			
Allergies			
Medication Allergies			
Disease/injury of joints			
Back problems			

Have you had?	Yes	No	Comment
Dental problems			
Eye problems			
Ear, nose, throat problems			
Asthma			
Allergies			
Medication Allergies			
Disease/injury of joints			
Back problems			

**Student's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Health Care Provider Signature (Acknowledging Review) -**

**Date** \_\_\_\_\_

Remarks or Additional Information. Comment on all positive answers. (Use additional sheet if necessary):

**PHYSICAL EXAMINATION**

**TO THE EXAMINER: PLEASE REVIEW THE STUDENT'S HISTORY AND COMPLETE THE PHYSICAL EXAMINATION AND IMMUNIZATION RECORD. PLEASE COMMENT ON ALL POSITIVE ANSWERS**

Name \_\_\_\_\_ Allergies \_\_\_\_\_  
 Last First Middle

Sex: Male \_\_\_\_\_ Female \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Pulse \_\_\_\_\_ Height \_\_\_\_\_ inches Weight \_\_\_\_\_ lbs.

Are there abnormalities in the following systems? Describe fully. Use additional sheet if needed. Please comment on all positive findings.

	Yes	No	Comments
Head, Ears, Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurologic			
Skin			
Psychiatric			

Is the patient now under treatment for any medical or emotional condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Is the patient taking any medication on a regular basis? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, list medications

\_\_\_\_\_

Is there a loss or seriously impaired function of any organ? Yes \_\_\_\_\_ No \_\_\_\_\_

Recommendations for physical activity:

(Intercollegiate Athletics, Intramurals, Physical Education) Unlimited \_\_\_\_\_ Limited \_\_\_\_\_

Explain

\_\_\_\_\_

Do you have any further recommendations for the care of this student? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain

\_\_\_\_\_

Name \_\_\_\_\_

**A. THE FOLLOWING PROOF OF IMMUNIZATIONS ARE MANDATORY (PLEASE ATTACH IMMUNIZATION RECORD FOR ALL VACCINES AND TITER RESULTS FOR HEPATITIS B AND ANY OTHER TITER AS INDICATED)**

**1. MEASELS (RUBEOLA), MUMPS, AND RUBELLA (German Measles):**

- Proof of two live vaccines (e.g. MMR) after 12 months of age for measles and mumps and one live vaccine (e.g. MMR) after 12 months of age for rubella OR serologic evidence of immunity (titer)

**2. VARICELLA:**

- Proof of two doses of vaccine OR serologic evidence of immunity (titer)

**3. HEPATITIS B:**

- Proof of three dose series of vaccine **AND** serologic evidence of immunity
- Students with low/negative titer results after completion of three dose series should discuss re-immunization with second three dose series, according to CDC recommendations for healthcare providers. A second serologic titer does not need to be submitted after second three-dose series of vaccine.

**All students must have begun the Hepatitis B Vaccine series prior to the start of classes. The series consists of three injections. An initial injection, followed by the second injection one month later, followed by the third injection five months after the second.**

**All students who have already completed the Hepatitis B vaccine series are required to have a Hepatitis B surface antibody titer (Blood Test) to confirm immunity. A copy of the lab report must be attached to this form. For students who are just beginning the Hepatitis B series, a titer is required one to two months after completion of the series.**

**B. Tetanus Toxoid, Reduced Diphtheria Toxoid, and Acellular Pertussis Vaccine:**

- Proof of Tdap vaccine within the past 10 years

**C. PPD: A BASELINE TWO-STEP PPD skin test is required. Students who can supply documentation of a two-step PPD test completed, in the past, require one single-step PPD.**

First PPD skin test: Date placed: \_\_ Date read: \_\_\_\_\_ Result: \_\_\_\_\_ mm of induration.

If negative,

2<sup>nd</sup> PPD skin test: Date placed: \_\_ Date read: \_\_\_\_\_ Result: \_\_\_\_\_ mm of induration.

(According to CDC guidelines for a two-step PPD, each PPD must be administered 1-3 weeks apart)

\*After initial two-step PPD, students are required to have a yearly single-step PPD

**D. PPD (Con't):**

**Positive PPD:** (Only for those who have had a positive PPD skin test)

- Date of positive test: \_\_\_\_\_
- **If PPD is positive, students must have a chest x-ray done after the date of the positive TB test.**

**Attach a copy of the result of the chest x-ray.**

- Attach healthcare provider documentation of any TB treatment, history of BCG vaccination, and absence of TB symptoms.

**E. YEARLY URINE DRUG SCREEN**

Attach copy of laboratory report for Urine Drug Screen which includes testing for ALL of the following substances:

- |                 |                    |            |                  |
|-----------------|--------------------|------------|------------------|
| 1. amphetamines | 3. benzodiazepines | 5. cocaine | 7. phencyclidine |
| 2. barbiturates | 4. cannabinoids    | 6. opiates |                  |

**F. YEARLY INFLUENZA VACCINE**

- **Required by October 31, 2024**

**G. Proof of COVID vaccination**

1<sup>st</sup> Date: \_\_\_\_\_

2<sup>nd</sup> Date \_\_\_\_\_

**H. Meningitis Information Response – Required of all resident students**

Date of Meningococcal immunization: \_\_\_\_\_

Date of Booster, if original vaccine prior to age 16 \_\_\_\_\_

**COMPLETE. Signature of health care provider indicates that practitioner has completed and reviewed all four pages of form.**

Health Care Provider \_\_\_\_\_

License #. \_\_\_\_\_

Address  
\_\_\_\_\_

Phone # \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Office Stamp