LYCOMING COLLEGE

STUDENT HEALTH SERVICES
Rich Hall (garden level)
570-321-4052
Hours during the academic year: 8:00 a.m. – 4:30 p.m.

PART-TIME / NON-DEGREE NEW STUDENT

HEALTH FORM

This form must be completed and returned prior to the first day of classes:

Mail to: Lycoming College
Student Health Services
One College Place
Box 144
Williamsport, PA 17701

Fax to: 570-321-4355

Welcome to Lycoming College. We hope your years at Lycoming are healthy ones.

Information requested on the Part-Time/Non-Degree Student Health Form is essential for the appropriate treatment of acute conditions, to ensure continuity of care for chronic conditions and to comply with statutes concerning student immunizations. All information contained in the health form is considered confidential and is not shared with other campus departments without student permission or, in cases in which student welfare is in jeopardy.

All spaces in the **immunization portion** must be filled in, blank spaces indicate incomplete vaccinations. Family physicians, as well as high school records and baby books are good places to check for dates of past immunizations. If you are unable to obtain immunization records, serological titers (blood work) may be sent as proof of vaccinations. Health Services also provides immunizations at a cost. Payment options are cash, check or charge to student ID. Receipts are available for those wishing to submit their own insurance claim forms.

CHECKLIST/DIRECTIONS FOR PREPARING AND RETURNING THE LYCOMING COLLEGE STUDENT HEALTH FORM

- ◯ I have completed **the student portion** of the Part-time/Non-Degree New Student Health Form
- ◯ I have **scheduled an appointment with my family doctor** to complete the physical examination and immunization portion of the health form
- ◯ I have taken the physical examination form to my physician for completion
- ◯ If I do not have all of the required immunizations, I have scheduled an appointment with my family doctor to receive missing vaccines.
- ◯ If I have received the **COVID-19 vaccine**, I have included a copy of my vaccination card.
- ◯ I have completed the Patient HIPAA Communication Form
- ◯ **I have made a copy of my health form for my personal records.**
- ◯ I have **mailed or faxed my health form** to Student Health Services prior to my first class.

LYCOMING COLLEGE
Student Health Services

HIPAA COMMUNICATION FORM
(disclosure to self and others)

Many patients allow family members (parents, grandparents, guardians, spouse) or close friends to call to discuss medical information, request prescriptions, request copies of medical records, discuss test results, pick up forms, etc. Due to various laws (including HIPAA), our staff cannot provide this information to anyone without the patient's consent except under emergency situations or other special circumstances permitted by privacy laws.

If you wish to have your authorization released to family/friends, you must sign this form. You may revoke this authorization at any time by notifying our office in writing.

Patient Name _____ Date of Birth _____

Patient Phone # _____

Disclosure to:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Alternate Communication
Health Services uses a variety of ways to communicate important information to you (test results, follow-up appointments, changes to your treatment plan, etc.). These methods include, but may not be limited to, the following: Mail to campus address, mail to home address, email, phone call to home phone, text, or call to cell phone. Unless you otherwise object, brief messages will be left on answering machines/voicemail. Please notify our staff if you would like to make changes to any of the above means of communication.

Patient Signature **X**_____ Date _____

At your initial visit to Student Health Services you will be provided a copy of our **Notice of Privacy Practices**
You will be asked to initial _____ and date _____ this form at that time indicating receipt.

LYCOMING COLLEGE
Student Health Services
One College Place – Box 144 – Williamsport, PA 17701-5192
Phone 570-321-4052 Fax 570-321-4355 email health@lycoming.edu

PART-TIME / NON-DEGREE STUDENT HEALTH RECORD

DEMOGRAPHICS — TO BE COMPLETED BY STUDENT

Legal Name _____
Last First Middle
Preferred Name _____
Home Address _____
City _____State _____ Zip _____
Home Telephone (_____) _____
Student Cell (_____) _____
Citizenship _____

Anticipated Graduation Year ____
Date of Birth _____
Place of Birth _____
Sex Assignment at Birth M/F ____
Gender Identity _____
Preferred Pronoun _____

EMERGENCY NOTIFICATION

Name _____ Relationship _____ Cell # _____

Daytime Phone _____ Evening Phone _____
Would your emergency contacts primary language of communication be English? Yes / No If no, please list preferred language _____

MISSING PERSON NOTIFICATION

◯ Check if missing person notification is the same as emergency notification. If not, please complete.
Name _____ Relationship _____ Cell # _____

Daytime Phone _____ Evening Phone _____
Would your missing person contacts primary language of communication be English? Yes / No If no, please list preferred language _____
Alternate Contact:
Name _____ Relationship _____ Cell # _____

Daytime Phone _____ Evening Phone _____
Would your missing person contacts primary language of communication be English? Yes / No If no, please list preferred language_____

INSURANCE INFORMATION

◯ Attach a copy of your health insurance card (front and back).
IF YOU DO NOT HAVE INSURANCE OR YOUR INSURANCE PLAN DOES NOT MEET OUR WAIVER REQUIREMENTS, YOU MUST ENROLL IN THE COLLEGE HEALTH PLAN

CONSENT FOR TREATMENT

I hereby grant permission to the nursing and physician staff at Lycoming College Student Health Services to render any treatment necessary.

X_____ **X**_____
Student Signature (required) Date Parent/Guardian Signature (required if student is under the age of 18) Date

I hereby authorize Lycoming College Student Health Services to release medical information to any licensed physician, hospital, clinic, or other medical personnel for the purpose of diagnosis and treatment. I understand that information will be released only in the event of an emergency or continuation of care. I also authorize Lycoming College Student Health Services to receive medical records from UPMC Emergency Department for the purpose of follow-up/on-going care. A photocopy of this authorization shall be considered as effective and valid as the original. It shall remain in effect while enrolled at Lycoming College or written withdrawal of consent is received in the Student Health Services office.

X_____ **X**_____
Student Signature (required) Date Parent/Guardian Signature (required if student is under the age of 18) Date

PHYSICAL EXAMINATION **TO BE COMPLETED BY A HEALTH CARE PROVIDER**

***a copy of a recent physical within the last 3 years may be substituted**

Student Name _____ Date of Birth _____
Last First Middle

Current prescription and nonprescription medication(s) with dosage(s): ◯ No ◯ Yes, please list:

_____

Medication Allergies: ◯ No ◯ Yes _____

Food Allergies: ◯ No ◯ Yes _____

Dietary restrictions _____

Is this student under treatment for any physical conditions? _____

General comments/recommendations _____

Temperature _____ Pulse _____ Blood Pressure _____ Height _____ Weight _____

	Normal	Not examined	Abnormal – Describe Findings
Head, Ears, Nose and Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neurological			# of concussions _____
Skin			
Neuropsychiatry			

COVID-19 VACCINATION **ATTACH A COPY OF YOUR VACCINE CARD**

Dose #1 _____ Dose #2 _____ ◯ Moderna ◯ Pfizer ◯ Johnson & Johnson

Booster Date _____ ◯ Moderna ◯ Pfizer ◯ Johnson & Johnson

REQUIRED IMMUNIZATIONS

	1st Dose Date	2nd Dose Date	3rd Dose Date	4th Dose Date
MMR (Measles/Mumps/Rubella) Two (2) doses given at least 28 days apart (required if born after 1956)				
Tdap (Tetanus/Diphtheria/Pertussis) Within the last 10 years				
Varicella (Chicken Pox) Two (2) doses given at least 28 days apart or had disease			**Year/Age had Chicken Pox:**	

SEROLOGICAL TITERS (blood work) may also be sent as proof of vaccine if records are not available

Date of examination_____ Printed Name of Physician_____

Signature of Physician_____

Street Address_____ City_____State_____ Zip _____

Phone _____ Fax _____

MAIL FORMS TO: Lycoming College – Student Health Services
One College Place, Box 144
Williamsport, PA 17701-5192

- or -

FAX FORMS TO: 570-321-4355