# STUDENT MEDICAL REPORT FORM

This document is MANDATORY for all incoming students. Please send all forms to the health office prior to the deadline date. A failure to do so will result in an academic hold and the inability to register for classes. All information attained from the Student Medical Report Form is confidential and only viewed by the medical staff in the Student Health Center. The information in this document will not be released to anyone without consent. A consent to release medical information form must be signed by the student for the medical staff to speak with any other party about any medical care provided or any health history.

#### PLEASE MAIL ALL FORMS TO STUDENT HEALTH CENTER – 201 Wood St., Pittsburgh, PA 15222. OR EMAIL IN PDF FORM TO Studenthealth@pointpark.edu

Term of Entry: Fall  Spring  Year 20	Housing status	Fall Deadline : August 1
Freshman 🗆 Transfer 🗆 Readmit 🗆	On Campus 🗌 Off Campus 🗆	Spring Deadline : Jan 1

### Student Demographics

Please complete all pages and print legibly

Last Name	First Name (official)			Middle Name		
Preferred Name	DOB		Gender	nder		
Student personal phone number Student			Student II	ID		
School Address (Please identify which dorm building)						
Home Address <i>(City, State, Zip)</i>				International? Yes  No Country:		
Student Email address						
Student athlete : Yes  No  If so, what team?		Major				
Primary Care Physician						

Name	Phone #
Emergency Contact	

Name	Relationship	
Phone Number	· ·	

Name	Relationship
Phone Number	

Student Health Center

#### 3<sup>rd</sup> Floor, Student Center Phone 412-392-3800 studenthealth@pointpark.edu

**Health History** (*You may need to continue providing information on additional page*)

Have you had?	Yes	No	Have you had?	Yes	No	Have you had?	Yes	No
Eye trouble			Tumors/cancer/cysts			Anxiety		
Ear trouble			Breathing problems/asthma			Depression		
Throat Problems			Stomach problems			Other mental health		
Diabetes			Weight/eating disorder			Head injury		
Skin trouble			Chronic migraines/headaches			Concussion		
Heart problems			Seasonal allergies			Date(s)		
Disease/injury of joints			Hearing difficulty			Cleared?		
Seizures			Insomnia					
Dizziness/fainting			Back/spinal cord problems					

Do you have any medication allergies? No 🗆 Yes 🗆 If yes, please list : \_\_\_\_\_\_

Do you have any food allergies? No 🗆 Yes 🗆 If yes, please list : \_\_\_\_\_\_

Have you had any major illnesses (Medical, surgical, or psychiatric) in the past? No 
Yes 
If yes, please list : \_\_\_\_\_

Do you take any medication regularly (prescription, over the counter, vitamins and/or herbal supplements)? No 
Yes 
If yes, please list :\_\_\_\_\_\_

## Health Insurance

Insurance Company	Group #
Name of Primary	Member ID#
Address	Phone

### Consent:

I give my consent for medical care and/or emergency treatment while I am enrolled at Point Park University. Care will be determined by the judgement of the Student Health Center medical staff. I agree to be responsible for any costs associated with any of the above-mentioned care which are not covered by my personal health insurance. I am aware that a copy of applicable HIPAA documents may be obtained by the student from the health center.

Student's Signature	Date	Signature of Parent or Guardian (Only if student is under 18 years of age)
	2	Student Medical Report Form

## Needs Assessment

The success of our students depends on many factors. Part of our commitment to wellness at Point Park University is to ensure students have access to the correct resources. Use the form below to help us meet the needs of our students. If you designate a need, we will provide the corresponding office's information on its services and how to access them. This information is kept confidential.

Do you need assistance transferring prescription medications to Pittsburgh for refills? No  $\square$  Yes  $\square$ 

Have you struggled with or do you currently struggle with any mental health challenges? No 
Yes 
If yes, please describe:

Would you be interested in connecting with the University Counseling Center? No  $\square$  Yes  $\square$ 

In the past, have you had any accommodations for any disability in school? No 
Yes 
If yes, please describe \_\_\_\_\_

Do you plan to request accommodation at PPU? No  $\Box$  Yes  $\Box$  If yes, be advised that to request medical or other reasonable accommodations individuals must register with Accessibility Services and provide all necessary documentation to Accessibility Services by July 1, 2024.

Do you need assistance contacting Accessibility Services? No  $\square$  Yes  $\square$ 

Do you have difficulty affording food? No  $\square$  Yes  $\square$ 

Do you have difficulty affording hygiene items like soap, laundry detergent, menstrual care products? No 
Yes

Do you have difficulty affording any technology items that could impact your learning such as Wi-Fi, a computer, etc.?

No  $\Box$  Yes  $\Box$ 

Are you a veteran? No  $\Box$  Yes  $\Box$ 

Do you need help accessing veteran services or care? No 🗆 Yes 🗆 If yes, please describe: \_\_\_\_\_\_

Do you have any spiritual concerns or needs? No 
Per Yes 
If yes please describe: \_\_\_\_\_\_