

Lincoln University Health Form

MANDATORY — <u>All</u> entering students MUST have a completed Health Form on file (incoming freshman, transfer students, and re-admits). This information is strictly for Health Services use and will not be released without your knowledge and/or consent. **Please upload the completed form to your student portal at lionshealth.lincoln.edu. Sign-in using your Lincoln University email and password.**

AST NAME (PLEASE PRINT LEGIBLY)		,	FIRST NAME MIDDLE INITIAL				COLLEGE ID NUMBER			
IOME ADDRESS			CITY OR TOWN			STATE	ZI	ZIP CODE		DATE OF BIRTH
FUDENT'S CELL	PHONE NUMBER	1		STUDENT'S HO	OME PHONE NU	ИВЕR	SEMESTER EN	TERING	(FALL	OR SPRING) YEAR
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MERGENCY CO			IONSHIP TO ST	E OF MEDICA	DME PHONE NUI		□ YES	□ NC		REPHONE NUMBER
amily History	(The following	question	s relate to Par	rents, Grandpare	ents, and Siblir	igs)				
Age	e Condition o	f Health	Occupation	Age at Death	Cause of Dea	th		Yes	No	Relationship to Student
Father						Tubercu				
Mother						Diabete				
Bro/Sis						Kidney				
Bro/Sis						Arthritis				
Bro/Sis							h Disease			
Bro/Sis							, Hay Fever			
Bro/Sis						Epilepsy Convuls				
	AD (Please ✓)	ORY (PI			Y/N	Seasonal Allergies Pain and/or Pressure in Ches	Y/N	1 G		lder Trouble or Gallstones nt Diarrhea
AVE YOU HA	AD (Please ✓)	•	J Insomnia	nxiety epression ervousness Headaches Colds	•	Seasonal Allergies	Y/N	G R R D W St	ecurrer ecent V izzines eakne comach	
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Lincoln University Health Services Health Forms cont.

To the Healthcare Provider:

Please review the student's health form and comment on all positive answers. The information supplied will be used for providing health care, if this is necessary.

This information is strictly for the use of the Health Services Office and will not be released without student consent.

Failure to complete and return this form will delay registration. Return of completed form is MANDATORY for ALL entering students.

MANDATORY VACCINES: Date Date:	Last Name		F i	irst Name	Middle Initial		al Gender			
MANDATORY VACCINES: 1. DTaP or Tdap (Required within ten years of admission) Date:	Temperature	Pulse Respirations Blood Pressure					Height	Weight		
1. DTaP or Tdap (Required within ten years of admission) Date:	Vision	(Right Eye)		_(Left Eye)	Semester Entering:	□ Fall	or 🛘 Sp	ring Year		
2. MMR Date: Date: or Titer Report: 3. Varicella (Chicken Pox) Date: Date: or Titer Report: (*Must have two vaccine dates or positive ICG report attached; history of having disease is not acceptable) 4. Meningococcal vaccine	MANDATORY V	ACCINES:								
3. Varicella (Chicken Pox) Date: Date: or Titer Report: (*Mint have two vaccine dates or positive IGG report attached; history of having disease is not acceptable) 4. Meningococcal vaccine	1. DTaP or To	dap (Required within	n ten years of ad	mission) Date: _		_				
(*Must have two vaccine dates or positive IGG report attached; history of having disease is not acceptable) 4. Meningococcal vaccine Date: (Not required for commuters) COVID-19 VACCINATION INFORMATION: Which vaccine did you receive? (circle answer) MODERNA PFIZER JOHNSON & JOHNSON Date of 1st dose: Date of 1st dose: Date of 2st dose: Booster date: Reading date: Results: Negative or Positive Induration	2. MMR	Date:		Date: _		_	or Titer Rep	ort:		
COVID-19 VACCINATION INFORMATION: Which vaccine did you receive? (circle answer) MODERNA PFIZER JOHNSON & JOHNSON Date of 1st dose: Date of 2st dose: Booster date: Date of 2st dose: Booster date: Date of 1st dose: Date of 2st dose: Booster date: Date of 1st dose: Date of 2st dose: Booster date: Date of 1st dose: Date of 2st dose: Dose 2st dose: Dose 2st Dose 2st Dose 2st Dose 2st Dose 3st Dose 3st Dose 2st Dose 3st Dose 2st Dose 2st Dose 3st Dose 3st Dose 2st Dose 2st Dose 2st Dose 3st Dose 2st Dose 3st Dose 2st Dose 3st Dose 2st Dose 3st										
Date of 1" dose: Booster date: TB Screening form completed: Yes No	4. Meningocoo	ccal vaccine	Date:		(Not required for co	ommuters)			
TB Screening form completed:	COVID-19 VACC	INATION INFORM	ATION: Which	vaccine did you	receive? (circle answer)	MODI	ERNA PFIZ	ZER JOHNSON & JOHNSON		
Results: Negative or Positive Indurationmm (If positive result, must have a negative chest x-ray report attached. If QuantiFERON Gold test is done, must attach report) RECOMMENDED: (For students who will possibly be exposed to blood and/or body fluids in a clinical and/or research setting) Hepatitis B: Dose 1: Dose 2: Dose 3: Polio: Date Series Completed: Date of last booster: Influenza: Last dose received: URINALYSIS OR URINE DIP STICK: Glucose: Ketones: pil: Leukocytes: Nitrites: Blood: If Indicated (Serum): Hgb/Hct: Glucose: Na+: K+: Are there any abnormalities of the following? Head, Ears, Nose or Throat Respiratory Cardiovascular Gastrointestin: Hernia Eyes Genitourinary Musculoskeletal Metabolic/Endocrine Neuropsychiatric Skin Is there loss or seriously impaired function of any above organ? No Yes Current Medications: Physical Restrictions: Do you have any recommendations regarding the care of this student? Please upload your forms to: Lionshealth,lincoln.edu				Date of 1st	dose: Dat	te of 2nd do	ose:	Booster date:		
RECOMMENDED: (For students who will possibly be exposed to blood and/or body fluids in a clinical and/or research setting) Hepatitis B: Dose 1:	_	-		Results:	Negative or I	Positive	Induration	mm		
Hepatitis B: Dose 1: Dose 2: Dose 3: Polio: Date Series Completed: Date of last booster: Influenza: Last dose received: Bl: Blood:										
Polio: Date Scries Completed: Date of last booster: Influenza: Last dose received: Ketones: pH: URINALYSIS OR URINE DIP STICK: Glucose: Ketones: pH: Leukocytes: Nitrites: Blood: If Indicated (Serum): Hgb/Het: Glucose: Na+: K+: Are there any abnormalities of the following? Head, Ears, Nose or Throat Respiratory Cardiovascular Gastrointestin: Hernia Eyes Genitourinary Musculoskeletal Metabolic/Endocrine Neuropsychiatric Skin Is there loss or seriously impaired function of any above organ? No Yes Current Medications: Physical Restrictions: Do you have any recommendations regarding the care of this student? Is the student currently under treatment for any medical or emotional condition? Healthcare provider Signature: Date: Please upload your forms to: Lionshealth.lincoln.edu Sign in using your LU credentials		·		-	•			G,		
Influenza: Last dose received: Ketones: pH:	•									
Leukocytes: Nitrites: Blood: K+: K+: Ma+: K+: K+: Ma+: K+: K+: Ma+: K+: Ma+: Ma+: Ma+: Ma+: Ma+: Ma+: Ma+: Ma+:					Date of la	st booster	:			
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Are there any abnormalities of the following? Head, Ears, Nose or Throat Respiratory Cardiovascular Gastrointestina Hernia Eyes Genitourinary Musculoskeletal Metabolic/Endocrine Neuropsychiatric Skin Is there loss or seriously impaired function of any above organ? No Yes Current Medications: Physical Restrictions: Do you have any recommendations regarding the care of this student? Is the student currently under treatment for any medical or emotional condition? Healthcare provider Signature: Date: Please upload your forms to: Lionshealth.lincoln.edu Sign in using your LU credentials	If Indicated (Serui	m): Hgb/H	Leukocytes: _ lct:	 Glucos	Nitrites:	I	Blood:			
Hernia Eyes Genitourinary Musculoskeletal Metabolic/Endocrine Neuropsychiatric Skin	`	, ,								
Current Medications:Physical Restrictions:	-					_	-			
Do you have any recommendations regarding the care of this student?	Is there loss or se	eriously impaired	function of any	y above organi	? □ No □ Yes					
Healthcare provider Signature:	Current Medicati	ions:			Physical Restriction	s:				
Healthcare provider Signature:Date:Please upload your forms to: Lionshealth.lincoln.edu Sign in using your LU credentials	Do you have any r	ecommendations reg	arding the care	of this student?						
Address: Lionshealth.lincoln.edu Sign in using your LU credentials	Is the student curr	ently under treatme	nt for any medic	al or emotional	condition?					
Address: Sign in using your LU credentials	Healthcare provid	ler Signature:			Date:		P	lease upload your forms to:		
	Address:						S	ign in using your LU		
	Print Last Name				Ofc Number		C	euchtais		