Lincoln University Health Form

MANDATORY – All 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.**

LAST NAME (PLEASE PRINT LEGIBLY) **FIRST NAME** **MIDDLE INITIAL** **COLLEGE ID NUMBER** **GENDER**

HOME ADDRESS **CITY OR TOWN** **STATE** **ZIP CODE** **DATE OF BIRTH**

STUDENT'S CELL PHONE NUMBER **STUDENT'S HOME PHONE NUMBER** **SEMESTER ENTERING (FALL OR SPRING)** **YEAR**

EMERGENCY CONTACT PERSON **RELATIONSHIP TO STUDENT** **HOME PHONE NUMBER** **CELL PHONE NUMBER** **WORK PHONE NUMBER**

DOES YOUR RELIGION PROHIBIT ANY TYPE OF MEDICAL TREATMENT? ☐ **YES** ☐ **NO**

Family History (The following questions relate to Parents, Grandparents, and Siblings)

	Age	Condition of Health	Occupation	Age at Death	Cause of Death			Yes	No	Relationship to Student
Father							Tuberculosis			
Mother							Diabetes			
Bro/Sis							Kidney Disease			
Bro/Sis							Arthritis			
Bro/Sis							Stomach Disease			
Bro/Sis							Asthma, Hay Fever			
Bro/Sis							Epilepsy, Convulsions			

PERSONAL HEALTH HISTORY (Please answer all questions; comment on all positive answers on a separate sheet of paper)

HAVE YOU HAD (Please ✓)	Y / N		Y / N			Y/N			Y/N	
Scarlet Fever			Insomnia			Seasonal Allergies			Gallbladder Trouble or Gallstones		
Measles/ Rubeola			Frequent Anxiety			Pain and/or Pressure in Chest			Recurrent Diarrhea		
German Measles/Rubella			Frequent Depression			Chronic Cough			Recent Weight Gain or Loss		
Mumps			Worry or Nervousness			Heart Palpitations			Dizziness and/or Fainting		
Chicken Pox			Recurrent Headaches			High or Low Blood Pressure			Weakness or Paralysis		
Malaria			Recurrent Colds			Rheumatic Fever or Heart Murmur			Stomach and/or Intestinal Trouble		
Gum and/or Tooth Trouble			Tuberculosis			Disease or Injury of Joints			Frequent Urination		
Hay Fever or Sinusitis						Back Problems			**Females Only:**		
Eye Trouble			Shortness of Breath			Tumor, Cancer, or Cyst			Irregular Periods		
Ear, Nose, Throat Trouble			Asthma			Jaundice			Severe Cramps		
Surgery:			Inhaler and/or Nebulizer Use			Seizure, Epilepsy			Excessive Flow		
Appendectomy			Name of Med			Anemia			**Are you on birth control?**		
Tonsillectomy						Sickle Cell			If yes, what kind?		
Hernia Repair			How Often Used								
Any Other Surgery											

DO YOU HAVE ANY DRUG OR FOOD ALLERGIES? (Example- penicillin, sulfonamides, etc.) If, so to what?

_____

	YES/NO	
Has your physical activity been restricted during the past five years? (If yes, give reasons and duration)		
Have you had difficulty with school, studies, or teachers? (If yes, give details)		
Have you received treatment or counseling for a nervous condition, personality or character disorder, or emotional problems? (If yes, give details)		
Have you had any illness or injury or been hospitalized other than already noted? (If yes, give details)		
Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past five years other than routine check-ups?		

_____ _____

STUDENT'S SIGNATURE (IF STUDENT IS A MINOR, PARENT OR GUARDIAN SIGNATURE IS REQUIRED) **DATE**

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.

Last Name _____ **First Name** _____ **Middle Initial** _____ **Gender** _____

Temperature _____**Pulse** _____ **Respirations** _____ **Blood Pressure** _____ **Height** _____ **Weight** _____

Vision _____ **(Right Eye)** _____ **(Left Eye)** **Semester Entering:** ☐ **Fall** **or** ☐ **Spring** **Year** _____

MANDATORY VACCINES:

1. **DTaP or Tdap (Required within ten years of admission) Date:** _____
2. **MMR** **Date:** _____ **Date:** _____ **or Titer Report:** _____
3. **Varicella (Chicken Pox) Date:** _____ **Date:** _____ **or Titer Report:** _____
   (*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 2nd dose:** _____ **Booster date:** _____

TB Screening form completed: ☐ **Yes** ☐ **No** **(If TB indicated)** **Date Administered:** _____ **Reading date:** _____
Results: **Negative or Positive** **Induration** _____**mm**

(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:** _____ **pH:** _____
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** ☐ **Gastrointestinal**
☐ **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:** _____

Address: _____

Print Last Name: _____ **Ofc Number**_____

Please upload your forms to:

Lionshealth.lincoln.edu
Sign in using your LU credentials