Elizabethtown College

Student Health
One Alpha Drive
Elizabethtown, PA 17022-2298
(717) 489-1021 Fax: (717) 361-0202

Submit Health Forms By:
For Fall: July 31st
For Spring: Jan 1st

Date of Entrance: (circle one) Fall Spring 20___

Name____ DOB______/______/________
Last First MI

Gender ☐ M ☐ F Social Security #______________________ College ID #__________________

Home Address____

Name of Parent/Guardian__________________________________Relationship________________

Home Phone_________________Work Phone__________________Cell Phone________________

Insurance Information: All students are required to have health insurance
_____ I plan to enroll in the college sponsored policy.
OR
Insurance Company Name____________________ Policy Holder________________

Policy or ID #__________________________ Group #_________________________

Prescription Plan: ☐yes ☐no

Please enclose a copy of front and back of insurance card & prescription card if different.

PERMISSION FOR TREATMENT

I hereby grant permission to Elizabethtown College, or its authorized representatives, to furnish such medical care as my son/daughter/self may require, including examination, treatment, immunizations, etc. This permission is conditioned upon the understanding that in the event of serious illness or the need for hospitalization and/or major surgery, the College will use all reasonable efforts to contact my next of kin. Failure in such efforts, however, should not prevent the College from providing such emergency treatment as may be necessary.

Signature______________________________________ Date______/_______/________

NOTE: Parent or legal guardian must sign if the student is under 18 years of age
Religious Preference (optional) ____

- **Student Health Office Use Only**- -

Insurance Complete ☐ yes ☐no
H&P Complete ☐ yes ☐no
Meningitis Vaccine: V W None (Circle One)

Incomplete For: (Circle)
MMR 1 2 Tdap or Td
HepB 1 2 3 Varicella 1 2
TST__________ PE_____________

MEDICAL HISTORY

PLEASE COMPLETE THIS PAGE BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

1. List any illness, medical or emotional condition for which you are being treated currently.

Condition | Year Diagnosed | Treatment

___

___

___

2. List any operations or hospitalizations you have had.

___

___

3. List all medications you are now taking (including over the counter, supplements, birth control pills, allergy serum, psychotropics)

Name of Medication | Dose | How Often

___

___

___

4. List your **ALLERGIES** to: Reaction:

Medications: ______________________________

Environment/Food/Insects: ______________________________

MEDICAL HISTORY—Check all applicable items, whether current or past problem. Give details in the space provided below.

____Congenital defects
____Frequent sore throats
____Sinusitis
____Frequent ear infections
____Hearing defects
____Serious eye defects
____Bronchitis
____Asthma
____Pneumonia
____Heart defects
____Rheumatic fever
____Irritable bowel syndrome
____Ulcer disease
____Inflammatory bowel disease
____Seizure disorder
____Fainting
____Neurologic disorder
____Headaches
____Arthritis
____Orthopedic infections
____Urinary tract infections
____Diabetes mellitus
____Endocrine problem
____Smoker
____Drug problem
____Alcohol problem
____Learning disability/ADD
____Mononucleosis
____Chickenpox
____Treatment by psychologist, psychiatrist, or counselor
____Menstrual disorder
____Skin disorder
____Eating disorder
____Concussion
____Other

Please provide details of above items checked:

___

___

FAMILY HISTORY

Have any of your relatives had any of the following?

	Yes	No	Relationship
Cancer			
Diabetes			
Heart Disease			
High Cholesterol			
High Blood Pressure			
Kidney Disease			
Lung Disease			
Tuberculosis			
Ulcer Disease			

___

Last name **First name** **MI** **DOB**

PHYSICAL EXAMINATION
(must be within 2 years of entrance)

Height_______ Weight ________lbs. BP_________/__________ Pulse__________

Specific Information – Are there any abnormalities of the following?

	No	Yes	If yes, please specify
Head, Eyes, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Recommendations for physical activity (varsity sports, intramurals):

☐ Unlimited ☐ Limited Explain: ____

Recommendations regarding care of this student: ____

Provider's Signature________________________________ Print Last Name______________________

Address: ____ Phone: ________________________________

____ Date: ________________________________

TB RISK ASSESSMENT – to be completed by medical provider:

If "YES" to any bolded question: Tuberculin skin test required within 12 months of entrance:

Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you ever had a positive TB skin test? ☐ Yes ☐ No

Have you ever had close contact with anyone who was sick with TB? ☐ **Yes** ☐ No

Were you born outside the U.S. and arrived in the U.S. within the past 5 years? If yes, what country**______________________________ ☐ **Yes** ☐ No

Have you ever traveled to/lived in another country?
If yes, what country(ies)**______________________________ ☐ **Yes** ☐ No

Have you ever been vaccinated with BCG? ☐ Yes ☐ No

Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities) ☐ **Yes** ☐ No

**Only countries considered High risk according to CDC should be included in TST testing.

Last name **First name** **MI** **DOB**

TST by Mantoux Skin Test (Tuberculin Skin Test)

If answered "yes" to any bolded question will need TST within 12 months of entrance:

Date of Test_______________ Signature of Provider Testing____

Date of Reading__________________ ☐Negative_________ mm ☐Positive__________ mm

Signature of Provider Reading Test____

If test Positive: Chest X-ray: Date_________________ Results: ☐Negative X-ray ☐Positive X-ray

Any Treatment____

Immunization Record

1. **MMR I** Date: ___________ **MMR II** Date: ____________ **or** Rubeola Titer ☐Positive ☐Negative, **and**
   (Dose 1 after 1st birthday and dose 2 at least 28 days after dose 1) Mumps Titer ☐Positive ☐Negative

2. **Varicella (Chickenpox) Year of Disease:____________, or**
   Immunization: **<u>Two Doses Required:</u> Dose #1** Date: ________________ **Dose #2** Date_____________**, or**
   Varicella titer: ☐Positive ☐Negative

3. **Tdap Booster (preferred)** Date: _________________ **Last Td Booster** Date:________________________
   The date of your last Tetanus booster must be **within the past 10 years.**

4. **Hepatitis B:** 2 doses of vaccine required prior to entrance/ 3 doses recommended
   Dose #1: ___________________ Dose #2: _____________________ Dose #3: _____________________**, or**
   Result of Hepatitis B Surface Antibody titer: ☐ Positive ☐ Negative

5. **List completion dates of following childhood series:**
   Polio: ____________________

6. **Other immunizations recommended, <u>but not required:</u>**
   Gardasil #1_______________ #2_________________ #3_________________

7. **This Section MUST BE COMPLETED BY ALL STUDENTS:**

<u>MENINGITIS Immunization Information</u>

Date of Most Recent Immunization:

____

(<u>Refer to Enclosed Meningitis Fact Sheet</u>)

OR

Waiver

I have received and reviewed the enclosed information regarding meningococcal disease. I am fully aware of the risks associated with this disease and of the availability and effectiveness of the vaccine. I knowingly decide not to receive the vaccine at this time.

___________________________________ ____________

Signature of Student **Date**

Last name **First name** **MI** **DOB**

Tests/Lab Work/Immunizations
***for Student Health office use only**

Date: ______________________ Date: ______________________
Date: ______________________ Date: ______________________
Date: ______________________ Date: ______________________
Date: ______________________ Date: ______________________

Problem List	Medications	Start	Stop

Allergies: ____

Return all Information to:
Student Health, Elizabethtown College
One Alpha Drive, Elizabethtown, PA 17022-2298
Phone: (717) 489-1021 Fax: (717) 361-0202
www.etown.edu/HealthServices.aspx

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