



Elizabethtown College
 Student Wellness/Student Health
 One Alpha Drive
 Elizabethtown, Pa. 17022
 (717)489-1021 Fax: (717)361-0202

2017/2018
 Please submit by:
 July 15th for Fall admissions
 Jan. 1st for Spring admissions

*The information provided is used solely for providing health care, if necessary, while you are a student.
 *Immunizations are required to be current thereby reducing public health risks on campus.

Name _____ DOB ____/____/____
Last First MI MM DD YYYY

Gender: ___M ___F ___Transgender ___Prefer not to answer Student Cell Phone (____) _____

Race/Ethnicity: ___African American/Black ___Anglo American/White ___Asian/Pacific Islander
 ___Hispanic/Latino ___International Student ___More than 1 race/ethnicity

Street Address _____ City/Town _____ State _____ Zip Code _____

Name of Parent(s)/Guardian _____ Emergency contact: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Elizabethtown College has a mandatory health insurance requirement. Please complete this section with your insurance information. This does not take the place of the online waiver process for the school sponsored plan.
Please check one:

___ I have health insurance and have verified that it will cover me at college. **A copy of the front and back of the Insurance card is required, please attach. (Include prescription coverage card also, if different).**

Insurance Company Name _____ Name of Insured _____

Insured's DOB ____/____/____ Policy or ID# _____ Group # _____
MM DD YYYY

OR ___ I plan to enroll in the College sponsored insurance plan.

Privacy and Confidentiality of Protected Health Information

The Student Health division of Student Wellness at Elizabethtown College respects and protects the privacy and confidentiality of student health information. The duty of confidentiality, however, is not absolute, disclosure may be warranted to protect the student, others, and when required by law, such as for public health reasons. Protected Health Information, whether it be written, spoken, electronic or printed will receive the same level of protection. Health information may be shared with the written consent of the student.

By signing this and submitting these health forms, I am acknowledging that I have read and understand this information.

Student Signature _____ Date ____/____/____
MM DD YYYY

Return Health Forms to:
Student Health, Elizabethtown College
One Alpha Drive, Elizabethtown, PA 17022-2298
Phone (717) 489-1021 Fax (717) 361-0202 Attn: Eileen
wagenere@etown.edu

STUDENT MEDICAL HISTORY

Please list Allergies and describe reaction / or please indicate if no allergies: No known allergies

Medication _____

Food _____

Other _____

List any significant illnesses, injuries, surgeries and/or hospitalizations and approximate dates:

List any medications you are taking (including birth control, mental health medications, over the counter medications, vitamins and/or herbal supplements):

Medical History: check all current or past conditions not indicated above:

Eye disease/vision problem

Hearing loss

Asthma

Heart Disease

High/Low Blood Pressure

Blood or Clotting Disorder

Sickle Cell Anemia/Trait

Dizziness/Fainting

Anemia

Ulcer Disease

Irritable Bowel Syndrome

Digestive Problems

Thyroid Disorder

Kidney Disease

Liver Disease

Arthritis

Scoliosis

Fractures

Joint Injury

Neck and/or Back Problem

Neurological Disorder

Seizure Disorder

Recurrent Headaches/Migraines

Endocrine Disorder

Diabetes

Cancer

Tuberculosis

Mononucleosis/Epstein Barr virus

Chickenpox

Skin Disorder

ADD/ADHD

Drug/Alcohol Problem

Tobacco Use

Eating Disorder

Anxiety Disorder

Depression

Bipolar Disorder

Other Mental Illness

Other

Comments _____

Student Last Name

First Name

Middle Initial

Date of Birth

FAMILY HISTORY

Please indicate if your relatives (parents, grandparents, siblings) have had any of the following?

	Yes	No	Relationship	Deceased
Cancer				
Diabetes				
Heart Disease/Stroke				
Sudden cardiac death Prior to age 50				
High Blood Pressure				
Kidney Disease				
Sickle Cell Disease				
High Cholesterol				
Tuberculosis				

PHYSICAL EXAMINATION:

A copy of a recent exam (within 1 year of August 1, 2017) is acceptable, please attach copy.

Student's Name (Print) _____ Date of Birth _____

Date of Exam: _____ Weight _____ lbs. Height _____ inches BMI _____ % BP _____ / _____ Heart Rate _____

System	Normal	Abnormal	Please describe abnormal findings.
Head, Eyes, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Chronic Health Conditions _____

Current Medications _____

Allergies _____

Recommendations for mental and /or physical health care _____

Relevant Lab Results (may attach copies) _____

Recommendations for physical activity (varsity sports, intramurals):

Unlimited Limited Explain: _____

Provider's Printed Name : _____ (MD/DO/NP/PA)

Signature _____ Date _____

Address _____ State _____ Zip Code _____

Phone Number (____) _____ Fax Number (____) _____

Student Last Name	First Name	Middle Initial	Date of Birth
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TUBERCULOSIS (TB) SCREENING/TESTING FORM (REQUIRED)

Part I: Student Questionnaire:

1. Country of Birth _____
2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? ___Yes ___No
3. Were you born in one of the countries or territories listed below? ___Yes ___No (If Yes, please circle)

Afghanistan	Congo	Iran (Islamic Republic of)	Namibia	Singapore
Algeria	Côte d'Ivoire	Iraq	Nauru	Solomon Islands
Angola	Democratic People's	Kazakhstan	Nepal	Somalia South Africa
Anguilla	Republic of Korea	Kenya	Nicaragua	South Sudan
Argentina	Democratic Republic of the	Kiribati	Niger	Sri Lanka
Armenia	Congo	Kuwait	Nigeria	Sudan
Azerbaijan	Djibouti	Kyrgyzstan	Northern Mariana Islands	Suriname
Bangladesh	Dominican Republic	Lao People's Democratic	Pakistan	Swaziland
Belarus	Ecuador	Republic	Palau	Tajikistan
Belize	El Salvador	Latvia	Panama	Thailand
Benin	Equatorial Guinea	Lesotho	Papua New Guinea	Timor-Leste
Bhutan	Eritrea	Liberia	Paraguay	Togo
Bolivia	Estonia	Libya	Peru	Trinidad and Tobago
Bosnia and Herzegovina	Ethiopia	Lithuania	Philippines	Tunisia
Botswana	Fiji	Madagascar	Poland	Turkmenistan
Brazil	French Polynesia	Malawi	Portugal	Tuvalu
Brunei Darussalam	Gabon	Malaysia	Qatar	Uganda
Bulgaria	Gambia	Maldives	Republic of Korea	Ukraine
Burkina Faso	Georgia	Mali	Republic of Moldova	United Republic of
Burundi	Ghana	Marshall Islands	Romania	Tanzania
Cabo Verde	Greenland	Mauritania	Russian Federation	Uruguay
Cambodia	Guam	Mauritius	Rwanda	Uzbekistan
Cameroon	Guatemala	Mexico	Saint Vincent and the	Vanuatu
Central African Republic	Guinea	Micronesia (Federated	Grenadines	Venezuela (Bolivarian
Chad	Guinea-Bissau	States of)	Sao Tome and Principe	Republic of)
China	Guyana	Mongolia	Senegal	Viet Nam
China, Hong Kong SAR	Haiti	Montenegro	Serbia	Yemen
China, Macao SAR	Honduras	Morocco	Seychelles	Zambia
Colombia	India	Mozambique	Sierra Leone	Zimbabwe
Comoros	Indonesia	Myanmar		

(Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012)

4. Have you had frequent or prolonged visits** to one or more of the countries listed above? ___Yes ___No
(If yes, please place a **check** next to countries that apply, above)
5. Have you been a resident and/or employee of a high-risk congregate setting (for example: correctional facility, long-term care facility or homeless shelter)? ___Yes ___No
6. Have you been a volunteer or health care worker who served clients who are at increased risk of active Tuberculosis disease? ___Yes ___No
7. Have you ever been a member of any of the following groups that may have an increased incidence of latent Tuberculosis infection or active TB disease: Medically underserved, low income, or those abusing drugs or alcohol? ___Yes ___No

****The significance of the travel exposure should be discussed with a health care provider and evaluated.**

- If the answer is YES to any of the above questions, Elizabethtown College requires that you receive TB testing as soon as possible but at least 6 months prior to the start of the semester. See next page.....
- If the answer to all of the above questions is NO, no TB testing is needed or necessary.

EXCEPTION: ATTENTION ALL EDUCATION MAJORS:

NOTE: All students majoring in Education **must receive a TB skin test in order to participate in observation/ student teaching in the schools. Please see enclosed form from the Education Department.**

Student Last Name	First Name	Middle Initial	Date of Birth
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Part II: Clinical Assessment by Health Care Provider

Please verify the information in Part I. Persons answering “**YES**” to any of the questions in Part I need to have a PPD/ Mantoux TB skin test or Interferon Gamma Release Assay (IGRA) blood test, unless a previous positive test has been documented.

Does student have a history of a **positive** PPD / Mantoux skin test or IGRA blood test? ___Yes ___No

- If **Yes**, a chest x-ray is required, please attach report.

History of BCG vaccination? (history of BCG is not a contraindication to TB testing) ___ Yes ___No

Does student have signs or symptoms of active pulmonary Tuberculosis? (Cough > 3 weeks, with or without blood, chest pain, unexplained weight loss, fevers, night sweats, loss of appetite). ___Yes ___No

1. Tuberculin Skin Test (TST)/ PPD Mantoux Skin Test

(TST result should be recorded in millimeters(mm) of induration, transverse diameter)

Date Placed: ___/___/___ Date Read: ___/___/___
MM DD YY MM DD YY

Result _____mm of induration Interpretation: positive ___ negative ___

Interpretation guidelines:

>5mm is positive: recent close contacts of an individual with infectious TB, persons with fibrotic changes on a prior chest xray, organ transplant recipients or other immunosuppressed persons. HIV infected persons.

>10mm is positive: recent arrivals to the US (< 5 yrs) from high prevalence areas or who resided in one for a significant amount of time, injection drug users, mycobacterial lab personnel, residents, employees or volunteers in high risk congregate settings. Persons with medical conditions that increase the risk of progression to TB disease: silicosis, diabetes mellitus, chronic renal failure, certain types of cancer, gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive: persons with no known risk factors for TB.

OR

2. Interferon Gamma Release Assay (IGRA)

Date obtained: ___/___/___
MM DD YY

Result: ___negative ___positive ___indeterminate

- Please attach copy of lab test results.

Chest x-ray: (Required only if TST or IGRA is positive)

Date of Chest x-ray: ___/___/___ Result: ___Normal ___Abnormal
MM DD YY

- Please attach a copy of x-ray report.

Student Last Name

First Name

Middle Initial

Date of Birth

Immunization Record: Antibody titers are acceptable/ please attach copy of lab report

To be completed and signed by your health care provider.

1. **MMR (Measles, Mumps, Rubella) REQUIRED (Two doses required)**

- Dose 1 given at age 12 months or later: #1 ___/___/___
- Dose 2 given at least 28 days after the first dose: #2 ___/___/___

2. **Tetanus/Diphtheria/Pertussis REQUIRED**

- Tdap ___/___/___ Last Td ___/___/___

3. **Hepatitis B REQUIRED** #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

4. **Hepatitis A (Optional)** #1 ___/___/___ #2 ___/___/___

5. **Polio: List completion date:** ___/___/___

6. **Varicella (Chickenpox) REQUIRED 2 doses or History of Disease**

- Dose #1 ___/___/___
- Dose #2 ___/___/___
- Or History of Disease / Date: ___/___/___

7. **Human Papilloma Virus Vaccine: (Optional)**

- Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___

8. **Meningitis Vaccine: REQUIRED / SEE BOX BELOW:**

MENINGITIS VACCINE: REQUIRED by Pennsylvania State Law

Date of Meningitis Vaccination: ___/___/___

Note: If 1st dose of Meningitis vaccine was given before age 16 years old, a booster dose is required. 2nd dose: ___/___/___

OR / Waiver: I have had the opportunity to review the information on the Meningitis vaccine and Meningococcal disease. I am fully aware of the risks associated with this disease, the availability and effectiveness of the vaccine, but for religious or other reasons, I decline the vaccine for Meningitis at this time.

Signature _____ **Date** _____

9. **Meningitis B Vaccine: (Optional)**

- Trumemba: Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
- Bexsero : Dose #1 ___/___/___ Dose#2 ___/___/___

Vaccinations verified by:

Health Care Provider Name/Signature: _____ Date _____

Student Last Name

First Name

Middle Initial

Date of Birth

This page for Student Health office use only:

Problem List/ Medications/ Immunizations/ Lab tests

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Date: _____

Problem List	Medications/Treatments	Start	Stop

Allergies: _____

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

Insurance Complete yes no

H&P Complete yes no

Meningitis Vaccine: V____ W None (Circle One)

Booster required after age 16yrs. _____.

Meningococcal B Vaccine: _____ 1 2 3.

Incomplete For: (Circle)

MMR 1 2 Tdap or Td

Hep B 1 2 3 Varicella 1 2

TST _____ PE _____

Student Last Name

First Name

Middle Initial

Date of Birth