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

2019/2020
Please submit by:
August 1st 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 ____Other **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 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

Please Mail or Fax 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 Health Diagnosis
__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, 2019) is also 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 (____) _____

TUBERCULOSIS (TB) SCREENING/TESTING FORM (REQUIRED)

Part I: Student Questionnaire:

Please answer the following questions:

Have you had close contact with anyone known or suspected to have active TB disease? ___Yes ___No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? ___Yes ___No (If Yes, please **circle**)

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

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

1. 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)
2. 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
3. Have you been a volunteer or health care worker who served clients who are at increased risk of active Tuberculosis disease? ___Yes ___No
4. 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.

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.

Student Last Name **First Name** **Middle Initial** **Date of Birth**

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.**

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: (1 dose *REQUIRED of Tdap) within the past 10 years***

   - **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 (Conjugate Vaccine/MCV): REQUIRED / SEE BOX BELOW:**

MENINGITIS VACCINE: REQUIRED by Pennsylvania State Law

Date of Meningitis (Conjugate/ MCV) 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 on 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: (Recommended, please discuss with your health provider)**
   - **Trumemba: Dose #1___/___/___ Dose #2___/___/___**
   - **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: __dose 1__dose 2

Incomplete For: (Circle)
MMR 1 2 Tdap or Td
Hep B 1 2 3 Varicella 1 2
TST_____PE_____
Jenzabar/vaccination data___

Student Last Name **First Name** **Middle Initial** **Date of Birth**