Other Significant Health Problems:

Explanations for all positive responses: (please refer to numbers above)

Allergies

Current Medications/Dietary Restrictions

Hospitalizations

Review of Systems to be completed by health care provider (other than parent)

(All “yes” answers must be fully explained below.)

Ears, Eyes, Nose, Throat

1. Eye Problems (blurred vision, infection, double vision, etc.)
2. Ear Infections
3. Decreased Hearing Acuity
4. Sinus Infections
5. Frequent Sore Throats
6. Mouth Ulcer

Cardiac

7. Murmurs
8. Palpitations
9. Chest Pain
10. High Blood Pressure
11. Other Heart Disease

Respiratory

12. Wheezes-Asthma
13. Frequent Colds
14. Chronic Cough
15. Treatment for Tuberculosis
16. Exposure to Tuberculosis
17. Smoker
18. Pneumonia

Gastrointestinal

19. Indigestion
20. Hemorrhoids
21. Gallbladder Disease
22. Constipation
23. Diarrhea
24. Rectal Bleeding
25. Recurrent Abdominal Pain
26. Gastroesophageal Reflux
27. Celiac Disease

Genito - Urinary

28. Kidney Disease
29. Recurrent Urinary Tract Infection
30. Painful Urination
31. Kidney Stones
32. Irregular Menses
33. Dysmenorrhea

Neuro-psychologic

34. Headaches
35. Seizures
36. Paresthesias
37. Sensory Loss
38. Weakness
39. Mood Disorder
40. Eating Disorder
41. Sleeping Disorder
42. Anxiety
43. Depression

Musculoskeletal

44. Joint Problems
45. Back Problems
46. Neck or Spinal Injury
47. Tendonitis or Bursitis

Other

48. Diabetes
49. History of Malaria
50. Cancer
51. Other Chronic Disease or Disability
Student Name ____________________________________________ DOB ________________________

To be completed by health care provider (other than parent).

Physician Examination  Date: _______________________

<table>
<thead>
<tr>
<th>Height (inches)</th>
<th>Weight (pounds)</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Resp</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visual Acuity:</td>
<td>with correction</td>
<td>without correction</td>
<td></td>
<td>left</td>
<td>right</td>
</tr>
</tbody>
</table>

Labwork REQUIRED

Hemoglobin or Hematocrit (within the last 12 months):  Hgb ________________________ Hct ________________________

Check if normal or abnormal

- Nutrition
- Development
- Skin
- Eyes/Vision
- Ears/Hearing
- Nose/Sinuses
- Teeth/Gum
- Neck/Thyroid
- Lymph Glands
- Thorax/Breasts
- Lungs
- Heart/Cardiovascular
- Abdomen (Hernia)
- Back
- Musculoskeletal System
- Neurological System
- Deep Tendon Reflexes
- Personality/Emotional

Summary of significant findings in history or physical exam:

How long have you known this patient? ________________________

Has this patient ever had any restrictions as to the kind or amount of exercise the patient may take?

☐ No  ☐ Yes  Please explain: ________________________

Is it advisable that this restriction be continued?

☐ No  ☐ Yes  Please explain: ________________________

Has patient ever had a major emotional problem or demonstrated abnormal behavior, of which we should be aware?

☐ No  ☐ Yes  If yes, please describe:

I have reviewed the history and examined this patient and find the patient physically fit to attend college and participate in all physical activities:  ☐ Yes  ☐ No

☐ Yes, with the following exceptions: ________________________

Name ____________________________________________ M.D./D.O.  Signed ________________________ M.D./D.O.  

Address ____________________________________________ Telephone ________________________
Student Name __________________________ Last Name __________________________ First Name __________________________ DOB __________________________

Student MUST enter these vaccine dates online via the Patient Portal (https://brynmawr.medicatconnet/login.aspx).

REQUIRED

Hepatitis B #1 __/__/____
MM DD YYYY
Hepatitis B #2 __/__/____
MM DD YYYY
Hepatitis B #3 __/__/____
MM DD YYYY

Measles, Mumps, Rubella #1 __/__/____
MM DD YYYY
Measles, Mumps, Rubella #2 __/__/____
MM DD YYYY
Measles, Mumps, Rubella #3 __/__/____
MM DD YYYY

Tetanus, Diptheria, Pertussis (Tdap) __/__/____
MM DD YYYY

Meningitis Vaccine or Waiver:
Required to get vaccine or patient must sign waiver below.

Date of vaccine __/__/____
MM DD YYYY

I have read and understand the information about meningitis on page 4 and I decline the meningitis vaccine at this time. I understand that if I decide in the future that I want the vaccine, I can receive it at the Health Center and be billed.

Print Name ____________________________________________

Signature of Student ____________________________________

Tuberculosis testing:
All students must have a PPD, a quantiferon gold blood test or chest xray between September 1, 2016, and September 1, 2017.

If the PPD or quantiferon gold blood test is positive, the student must have a chest X-Ray:

PPD Date __/__/____
MM DD YYYY
Results: □ Negative □ Positive

Quantiferon Gold Date __/__/____
MM DD YYYY
Results: □ Negative □ Positive

Chest X-Ray Date __/__/____
MM DD YYYY
Results: □ Negative □ Positive

REQUIRED for international students from all countries except USA, Canada, Western Europe, Australia, and Japan.

Hepatitis A #1 __/__/____
MM DD YYYY
Hepatitis A #2 __/__/____
MM DD YYYY

RECOMMENDED

HPV #1 __/__/____
MM DD YYYY
HPV #2 __/__/____
MM DD YYYY
HPV #3 __/__/____
MM DD YYYY

Pneumococcal polysaccharide __/__/____
MM DD YYYY

Varicella #1 __/__/____
MM DD YYYY
Varicella #2 __/__/____
MM DD YYYY
Varicella disease __/__/____
MM DD YYYY

Provider: Please attach a copy of the patient’s immunization record.
Information on Meningitis

Meningitis is a rare but potentially fatal infection which can be caused by a virus or bacteria. Permanent brain damage, hearing loss, learning disability, limb amputation, kidney failure, or death can result from the infection. Research indicates that college students, particularly freshmen who live in dormitories or residence halls, have a six-fold increased risk of the disease. There is a vaccine available to protect against the bacterial form of the disease which is 85% to 100% effective in preventing four of the five common bacterial forms of meningitis which cause about 70% of disease in the United States. To date, the vaccine has proven to be safer, with mild and infrequent side effects, such as redness and pain at the injection site lasting up to two days. Immunity generally develops within seven to 10 days and remains effective for approximately three to five years. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals.

The decision of whether or not to receive the meningitis vaccine is a personal one. The American College Health Association and the Advisory Committee on Immunization Practices of the CDC recommend that college students, particularly freshmen, be educated about the disease and the potential benefits of vaccination. We urge you to discuss the question of having the vaccine with your physician and your parents.

In July 2002, the Pennsylvania Legislature passed a law requiring students who live in dormitories to either get the vaccine or sign a waiver indicating you have received information about the disease and the vaccine but opted not to get it. In order to comply with this law you are therefore REQUIRED to get the vaccine or sign the waiver on the Health Service Form. If you have questions, please call before May 17 or email your questions to sheimann@brynmawr.edu.