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

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

<table>
<thead>
<tr>
<th>System</th>
<th>Question</th>
<th>Response Yes</th>
<th>Response No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ears, Eyes, Nose, Throat</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Neuro-psychologic</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Yes/No</td>
<td>Yes/No</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

**Other Significant Health Problems:**

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

**Allergies**

**Current Medications/Dietary Restrictions**

**Hospitalizations**
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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>without correction</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>left</td>
<td>right</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Labwork REQUIRED**

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

Sickle Cell Testing (Required only if participating in athletics)  ☐ Negative  ☐ Positive

**Check if normal or abnormal**

- Normal ☐ Abnormal ☐ Nutrition
- Normal ☐ Abnormal ☐ Development
- Normal ☐ Abnormal ☐ Skin
- Normal ☐ Abnormal ☐ Eyes/Vision
- Normal ☐ Abnormal ☐ Ears/Hearing
- Normal ☐ Abnormal ☐ Nose/Sinuses
- Normal ☐ Abnormal ☐ Mouth/Throat
- Normal ☐ Abnormal ☐ Teeth/Gum
- Normal ☐ Abnormal ☐ Neck/Thyroid
- Normal ☐ Abnormal ☐ Lymph Glands
- Normal ☐ Abnormal ☐ Thorax/Breasts
- Normal ☐ Abnormal ☐ Lungs
- Normal ☐ Abnormal ☐ Heart/Cardiovascular
- Normal ☐ Abnormal ☐ Abdomen (Hernia)
- Normal ☐ Abnormal ☐ Back
- Normal ☐ Abnormal ☐ Musculoskeletal System
- Normal ☐ Abnormal ☐ Neurological System
- Normal ☐ Abnormal ☐ Deep Tendon Reflexes
- Normal ☐ Abnormal ☐ 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? ____________________________
- Is it advisable that this restriction be continued? ____________________________
- Has patient ever had a major emotional problem or demonstrated abnormal behavior, of which we should be aware? ☐ Yes ☐ No  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 MUST enter these vaccine dates online via the Patient Portal (https://brynmawr.medicatconnect/login.aspx).

*Required for all students for matriculation

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

*Tetanus, Diphtheria, Pertussis (Tdap) __________
   (within the last 7 years)

*Measles, Mumps, Rubella #1 __________

*Measles, Mumps, Rubella #2 __________

*Hepatitis B #1 __________

*Hepatitis B #2 __________

*Hepatitis B #3 __________

**Hepatitis A #1 __________

**Hepatitis A #2 __________

HPV #1 __________

HPV #2 __________

HPV #3 __________

Pneumococcal polysaccharide __________

Varicella #1 __________

Varicella #2 __________

Varicella disease __________

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

Date of vaccine __/__/____
   MM DD YYYY

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

________________________
Signature of Parent (if student is under 18 years of age)

*Tuberculosis testing:
Has the patient received BCG? ☐ Yes ☐ No
Within one year of matriculation, one of the following must be done:

PPD
Date __/__/____
   MM DD YYYY

Results: ☐ Negative ☐ Positive
   If PPD is positive, Chest X-Ray or Quantiferon Gold must also be done.

Chest X-Ray
Date __/__/____
   MM DD YYYY

Results: ☐ Negative ☐ Positive

Quantiferon Gold
Date __/__/____
   MM DD YYYY

Results: ☐ Negative ☐ Positive

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