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>
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<tr>
<th>Height (inches)</th>
<th>Weight (pounds)</th>
<th>BMI</th>
<th>Blood Pressure</th>
<th>Pulse</th>
<th>Resp</th>
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</table>

**Visual Acuity:**

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<th>with correction</th>
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#### Check if normal or abnormal

- Normal  
- Abnormal  

1. Nutrition  
2. Development  
3. Skin  
4. Eyes/Vision  
5. Ears/Hearing  
6. Nose/Sinuses  
7. Mouth/Throat  
8. Teeth/Gum  
9. Neck/Thyroid  
10. Lymph Glands  
11. Thorax/Breasts  
12. Lungs  
13. Heart/Cardiovascular  
14. Abdomen  
15. Back  
16. Musculoskeletal System  
17. Neurological System  
18. Deep Tendon Reflexes  
19. Personality/Emotional

#### Summary of significant findings in history or physical exam:

1. **How long have you known this patient?**
2. **Has this patient ever had any restrictions as to the kind or amount of exercise the patient may take?**
   - No  
   - Yes  
   - Please explain: 
3. **Is it advisable that this restriction be continued?**
   - No  
   - Yes  
   - Please explain: 
4. **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**  

**Date**
Student Name ___________________________ Last Name ___________________________ First Name ___________________________ DOB ___________________________ MM/DD/YYYY

Student MUST enter these vaccine dates online via the Patient Portal (https://brynmawr.medicatconnect.com/).

**REQUIRED** for international students from countries where hepatitis a is endemic (all countries except USA, Canada, Western Europe, Australia, and Japan)

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

**REQUIRED**

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

If history of illness, titer required:
- Reactive __________ Non Reactive __________
- Measles, Mumps, Rubella #1 __/__/____ MM DD YYYY
- Measles, Mumps, Rubella #2 __/__/____ MM DD YYYY
- Tetanus, Diphtheria, Pertussis (Tdap) __/__/____ (within the last 10 years) MM DD YYYY
- Meningitis Group A __/__/____ MM DD YYYY
- Meningitis Group B #1 __/__/____ MM DD YYYY
- Meningitis Group B #2 __/__/____ MM DD YYYY
- Polio Series ____/__/____ Completed: MM DD YYYY

**RECOMMENDED**

- HPV #1 __/__/____ MM DD YYYY
- HPV #2 __/__/____ MM DD YYYY
- HPV #3 __/__/____ MM DD YYYY
- Pneumococcal polysaccharide __/__/____ MM DD YYYY

**IN THE EVENT** of an outbreak of a vaccine preventable disease, students who have not received full immunization will be required to be separated from campus at their own expense.

Students will not be placed in housing until all health records and immunization forms are completed and submitted to the Student Health Center by July 1.

To the best of my knowledge this information is accurate.

__________________________________________
Clinician’s Signature Date

All students must complete the Tuberculosis screening questionnaire on the next page.

Provider: Please attach a copy of the patient’s immunization record.
Bryn Mawr College Health Center Tuberculosis Screening Questionnaire

Tuberculosis screening questionnaire must be completed by all students within six months of matriculation.

If answer no to all questions, all incoming Bryn Mawr College students must have had a PPD placed within six months of matriculation and results reported below.

If answer yes to any questions, and/or you are an international student, a blood test is required within 6 months of matriculation and results reported below.

Student MUST upload all completed forms online via the Patient Portal (https://brynmawr.medicatconnect.com/) by July 1.

Part 1: Screening Questionnaire to Be Completed by Student

Have you had close contact with persons known or suspected to have TB disease?  ❑ No  ❑ Yes

Were you born in, or have ever lived, worked, or visited for more than one month in any of the following: Asia, Africa, South America, Central America or Eastern Europe?  ❑ No  ❑ Yes

If yes, where?  How long?

Have you been a resident and/or employee of high-risk congregate settings (correctional facilities, long-term care facilities, and homeless shelters)?  ❑ No  ❑ Yes

Have you been a volunteer or health care worker who served clients who are at risk for active TB disease?  ❑ No  ❑ Yes

Have you been a member of any of the following groups that may have increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low income, or abusing drugs or alcohol?  ❑ No  ❑ Yes

Part 2: Clinical Assessment by Health Care Provider

History of positive TB skin test or IGRA blood test? If yes, document below.  ❑ No  ❑ Yes

History of BCG vaccine? (If yes, consider IGRA if possible.)  ❑ No  ❑ Yes

Does the student have signs of active TB, such as cough lasting longer than three weeks, coughing up blood, chest pain, loss of appetite, unexplained weight loss, night sweats, fevers?  ❑ No  ❑ Yes

If yes, proceed with additional evaluation to exclude active TB.

Tuberculin Skin Test (TST)

Date given: ___/___/___ Date read: ___/___/___ Result: ___mm induration Interpretation: ___positive ___negative

Interferon Gamma Release Assay (IGRA) circle one

Date Obtained: ___/___/___ Test Done: QFT-GIT  T-Spot  Result: ___positive ___negative ___ indeterminate

Must provide a copy lab report

Chest Xray: (REQUIRED if TST or IGRA positive)

Date of chest Xray: ___/___/___ Result: ___normal ___abnormal (Must provide a copy of chest Xray report/results)

I have reviewed the information included in this questionnaire with the patient, their individual risk for infection, as well as signs and symptoms of an active TB infection and when the student should seek care.

Health care provider signature              Date