BRYN MAWR COLLEGE

STUDENT HEALTH FORM

Student Name _____ **DOB** _____ **Date of Exam** _____
Last Name First Name MM/DD/YYYY MM/DD/YYYY

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

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
- ❑ Yes ❑ No 1. Eye Problems (blurred vision, infection, double vision, etc.)
- ❑ Yes ❑ No 2. Ear Infections
- ❑ Yes ❑ No 3. Decreased Hearing Acuity
- ❑ Yes ❑ No 4. Sinus Infections
- ❑ Yes ❑ No 5. Frequent Sore Throats
- ❑ Yes ❑ No 6. Mouth Ulcer

Cardiac
- ❑ Yes ❑ No 7. Murmurs
- ❑ Yes ❑ No 8. Palpitations
- ❑ Yes ❑ No 9. Chest Pain
- ❑ Yes ❑ No 10. High Blood Pressure
- ❑ Yes ❑ No 11. Other Heart Disease

Respiratory
- ❑ Yes ❑ No 12. Wheezes-Asthma
- ❑ Yes ❑ No 13. Frequent Colds
- ❑ Yes ❑ No 14. Chronic Cough
- ❑ Yes ❑ No 15. Treatment for Tuberculosis
- ❑ Yes ❑ No 16. Exposure to Tuberculosis
- ❑ Yes ❑ No 17. Smoker
- ❑ Yes ❑ No 18. Pneumonia

Gastrointestinal
- ❑ Yes ❑ No 19. Indigestion
- ❑ Yes ❑ No 20. Hemorrhoids
- ❑ Yes ❑ No 21. Gallbladder Disease
- ❑ Yes ❑ No 22. Constipation
- ❑ Yes ❑ No 23. Diarrhea
- ❑ Yes ❑ No 24. Rectal Bleeding
- ❑ Yes ❑ No 25. Recurrent Abdominal Pain
- ❑ Yes ❑ No 26. Gastroesophageal Reflux
- ❑ Yes ❑ No 27. Celiac Disease

Genito - Urinary
- ❑ Yes ❑ No 28. Kidney Disease
- ❑ Yes ❑ No 29. Recurrent Urinary Tract Infection
- ❑ Yes ❑ No 30. Painful Urination
- ❑ Yes ❑ No 31. Kidney Stones
- ❑ Yes ❑ No 32. Irregular Menses
- ❑ Yes ❑ No 33. Dysmenorrhea

Neuro-psychologic
- ❑ Yes ❑ No 34. Headaches
- ❑ Yes ❑ No 35. Concussion
- ❑ Yes ❑ No 36. Seizures
- ❑ Yes ❑ No 37. Paresthesias
- ❑ Yes ❑ No 38. Sensory Loss
- ❑ Yes ❑ No 39. Weakness
- ❑ Yes ❑ No 40. Mood Disorder
- ❑ Yes ❑ No 41. Eating Disorder
- ❑ Yes ❑ No 42. Sleeping Disorder
- ❑ Yes ❑ No 43. Anxiety
- ❑ Yes ❑ No 44. Depression

Musculoskeletal
- ❑ Yes ❑ No 45. Joint Problems
- ❑ Yes ❑ No 46. Back Problems
- ❑ Yes ❑ No 47. Neck or Spinal Injury
- ❑ Yes ❑ No 48. Tendonitis or Bursitis

Other
- ❑ Yes ❑ No 49. Diabetes
- ❑ Yes ❑ No 50. History of Malaria
- ❑ Yes ❑ No 51. Cancer
- ❑ Yes ❑ No 52. Other Chronic Disease or Disability

Other Significant Health Problems:

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

Allergies

Current Medications/Dietary Restrictions

Hospitalizations

next>>>

Student Name _____ **DOB** _____ **Date of Exam** _____
Last Name First Name MM/DD/YYYY MM/DD/YYYY

TO BE COMPLETED BY HEALTH CARE PROVIDER (OTHER THAN PARENT).

Physician Examination Date: _____

_____
Height (inches) Weight (pounds) Blood Pressure Pulse Resp

Visual Acuity: with correction _____ without correction _____
left right left right

Check if normal or abnormal

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

Summary of significant findings in history or physical exam:

How long have you known this patient? _____

Does this patient have any restrictions as to the kind or amount of exercise the patient may take?

❑ No ❑ Yes Please explain: _____

To ensure continuity of care, Counseling Services reaches out to students with mental health concerns. Our goal is to inform them of services such as individual counseling, support groups, crisis intervention, and medication management. In your opinion, would this outreach be approrpiate this student?

❑ No ❑ Yes Please explain: _____

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

❑ Yes, with the following exceptions: _____

_____ _____
Name C.R.N.P./M.D./D.O. Signed C.R.N.P./M.D./D.O. Date

_____
Address Telephone

next>>>

Student Name _____ **DOB** _____ **Date of Exam** _____
Last Name First Name MM/DD/YYYY MM/DD/YYYY

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

REQUIRED

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, Diptheria, Pertussis (Tdap) __/__/____
(within the last 10 years) MM DD YYYY

Meningitis AYCW #1 __/__/____
MM DD YYYY

Meningitis AYCW #2 __/__/____ if first one was younger than 16 years old
MM DD YYYY

Polio Completed Series __/__/____
MM DD YYYY

Covid Vaccine:

Name of vaccine _____

Dose #1 __/__/____
MM DD YYYY

Dose #2 __/__/____
MM DD YYYY

Dose #3 __/__/____
MM DD YYYY

RECOMMENDED

HPV #1 __/__/____
MM DD YYYY

HPV #2 __/__/____
MM DD YYYY

HPV #3 __/__/____
MM DD YYYY

Pneumococcal polysaccharide __/__/____
MM DD YYYY

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

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

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

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

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

Meningitis Group B #1 __/__/____
MM DD YYYY

Meningitis Group B #2 __/__/____
MM DD YYYY

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

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.

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.

next>>>

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

Student Name _____ **DOB** _____ **Date of Exam** _____
Last Name First Name MM/DD/YYYY MM/DD/YYYY

Bryn Mawr College Health Center Tuberculosis Screening Questionnaire

Note: this form must be signed by a helthcare provider.

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

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 this completed form online via the Patient Portal (https://brynmawr.medicatconnect.com/login.aspx) 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