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BRYN MAWR
COLLEGE

STUDENT HEALTH FORM

Student Name ______________________________ **DOB** ______ **Date of Exam** ________

Last Name First Name MM/DD/YYYY MM/DD/YYYY

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

THIS FORM TO BE COMPLETED WITHIN THE LAST YEAR BY HEALTH CARE PROVIDER (OTHER THAN PARENT). PLEASE CHECK ANY CONCERNS THAT APPLY:

REVIEW OF SYSTEMS: *(Explain all "yes" answers.)*

Ears, Eyes, Nose, Throat, Mouth
❑ Yes ❑ No

Gastrointestinal
❑ Yes ❑ No

Neuro-psychologic/psychiatric
❑ Yes ❑ No

Cardiac
❑ Yes ❑ No

Genito - Urinary
❑ Yes ❑ No

Musculoskeletal
❑ Yes ❑ No

Respiratory
❑ Yes ❑ No

Allergies/Dietary Restrictions
❑ Yes ❑ No

Medications

Gender: ______________________

How long have you known the patient? ______________________

Physician Exam: ______________________

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/Neck	❑ 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

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 benefit this student? ❑ No ❑ Yes May help: ______________________

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

Address Telephone

Student Name ____ **DOB** _______
Last Name First Name 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:

Manufacturer 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.

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 healthcare 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

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) (if indicated based on answers above).

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

Bryn Mawr College
Health and Wellness Center – Medical Services
Consent for Treatment

I hereby consent for Bryn Mawr College Health and Wellness Center Medical Services ("BMC Medical Services"), and its affiliated medical providers, nurses, and/or allied health professional students employed or participating in a clinical rotation, to provide medical services to me. I am authoring BMC Medical Services to treat me during my relationship with the College as an enrolled student unless and until I withdraw my consent in writing. I acknowledge that I am responsible for all charges incurred in connection with the medical care and services provided and I also understand that I am financially responsible for all charges incurred for any and all services that I receive from other providers outside of BMC Medical Services, even if BMC Medical Services recommends those other services or recommends those other services or refers me to such other providers. I approve the release of medical diagnostic information to my insurance company for payment purposes. I hereby certify that I have read fully the above authorization and by my signature below I consent to the above and further understand that no assurance or guarantee has been or will be made regarding the results of any medical services provided by BMC Medical Services, including but not limited to the provision of medical treatment or evaluation. In addition, I acknowledge that I have reviewed Bryn Mawr College's Medical Service Notice of Privacy Practices document.

______________________________ ______________________

Student's Signature (18 years of age or older) Date

______________________________ ______________________

Parents' Signatures (if student is 18 years of age or younger) Date