BRYN MAWR COLLEGE

GRADUATE STUDENT HEALTH FORM

Check one box: ❑ **GSSW** ❑ **GSAS**

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/). Due July 1.

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: (3 required)

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

All immunization forms are to be 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.

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

_____ _____
Clinician's Signature Date

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

next>>>

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

Bryn Mawr College Health Center Tuberculosis Screening Questionnaire
First Name

Note: this form must be signed by a health care 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

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

Date of Birth: _____