Student Health Center
Health Information Packet
For All Students
Packet is required of all students

Packet Checklist

- Student Information Page
- Health History Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health History Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Hipaa/Ferpa/Insurance Form
- Copy of Insurance Card
- Immunization Record Form (to be reviewed and signed by physician)
- Health Services TB Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health Services TB Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Physical Form Part 1 (to be completed by physician)
- Physical Form Part 2 (to be completed and signed by physician)

Instructions

Once the Health Information Packet has been reviewed and completed, it can be submitted to Admissions, mailed to the Student Health Center, or submitted by fax to the Student Health Center. Fall freshmen must return the completed health form by July 1st or four weeks before the start of the term for winter and spring terms.

- Keep a COPY of this form, and any attachments for your records
- Submission of this form is MANDATORY for all BAC students
- Athletes: to participate in a sport at BAC a COMPLETED medical form MUST BE SUBMITTED to Bryn Athyn Health Services PRIOR to ANY NCAA tryout/participation.

About the Student Health Center

The Student Health Center is the primary health care facility for the College. The purpose is to provide direct health care services while assisting students to take responsibility for their own health and wellness. The Health Center hours of operation are available on the Health Services web page.

2945 College Drive, Box 915, Bryn Athyn, PA 19009 | https://www.brynathyn.edu/health
Phone: 267-502-6070 | Fax: 267-502-6024
FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.

Student Information

NAME:________________________________________________________________________________________________________

ADDRESS: _____________________________________________________________________________________________________

CITY: __________________________________________________________________________________________________________

STATE: _____________________________________________ ZIP: ________________________________________________________

HOME PHONE NUMBER: _________________________________________________________________________________________

STUDENT CELL PHONE NUMBER: _________________________________________________________________________________

BIRTH DATE: ____________________________________________________________________________________________________

SEX:   ☐ MALE    ☐ FEMALE

COUNTRY RAISED IN: ____________________________________________________________________________________________

COUNTRY OF BIRTH: _____________________________________________________________________________________________

CHECK ALL THAT APPLY: ☐ Undergraduate ☐ Resident ☐ Transfer ☐ Full Time ☐ Freshmen ☐ Sophomore
                     ☐ Theological School ☐ Commuter ☐ International ☐ Part Time ☐ Junior  ☐ Senior

Emergency Contact

NAME: __________________________________________________________  RELATIONSHIP: ________________________________

ADDRESS: ______________________________________________________________________________________________________

CITY: ___________________________________________________________________________________________________________

STATE: _____________________________________________ ZIP: ________________________________________________________

HOME PHONE NUMBER: _________________________________________________________________________________________

WORK PHONE NUMBER: _________________________________________________________________________________________

CELL PHONE NUMBER: ____________________________________________
MEDICATIONS (Prescription, non-prescription, vitamins, herbal, etc.)

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Times Taken Per Day</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

ALLERGIES/REACTIONS

<table>
<thead>
<tr>
<th>Medicine/Food/Agent</th>
<th>Reactions/ Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
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HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

A. NEUROLOGICAL
- Concussion (list dates): ________________________
- Cerebral Palsy
- Migraines/ Headaches
- Seizure Disorders

B. CARDIOVASCULAR
- Fainting
- Blood Disorder
- Heart Condition (list): ________________________
- Blood Pressure Abnormalities
- Heart Murmur
- Chest Pain/ Discomfort

C. GASTROINTESTINAL
- Chronic Inflammatory Bowel Disease
- Digestive Problems (describe): ________________________
- Acid Reflux
- Hernia
- Gallbladder Disease
- Liver Disease

D. GENITOURINARY
- Urinary Tract Infections
- Kidney Stones
- Kidney Disease

E. INFECTIOUS DISEASES
- Chicken Pox
- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus)
- Date: ________________________
- Positive TB Testing
- Date: ________________________
- Preventative INH Treatment for Tuberculosis
  Date: ________________________
  Length of Treatment: ________________________
- HIV

F. METABOLIC/ ENDOCRINE
- Diabetes Type 1/ Type 2
- Thyroid Disorder
- Hypoglycemia

G. RESPIRATORY
- Asthma/ Sports- Induced Asthma
  Asthma Medication: ________________________
- Seasonal Allergies: ________________________
- Shortness of breath

H. MEN’S HEALTH
- Testicular Problems

I. WOMEN’S HEALTH
- Irregular Menses
- Painful Menses
- Last menstrual period ________________________

Student: please fill out this page and take to physical | Physician: please review during physical
J. PSYCHOLOGICAL OR SOCIAL
- Alcohol/Drug Abuse Problems
- Anxiety
- Depression
- Eating Disorder
- Panic Attack
- Insomnia
- ADD/ADHD
- Learning Disability
- Suicide Attempt
- Psychiatric Admission

K. ILLNESSES NOT LISTED ABOVE: ________________________________
<p>| | | |</p>
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</table>

L. SURGERIES AND HOSPITALIZATIONS
Dates: Specify reason:
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</table>

M. ORTHOPEDIC HISTORY - Have You Ever Had an Injury to:
- Shoulder (describe): __________________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Elbow/Wrist/Arm/Hand (describe): _________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Lower Leg (describe): __________________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Knee (describe): ______________________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Ankle/Foot (describe): _________________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Hip/Groin (describe): __________________________________________
  |                          |                          |                          |
|                          |                          |                          |
- Back/Ribs (describe): _________________________________________
  |                          |                          |                          |

N. FAMILY HISTORY
Have any of your blood relatives had any of the following?
- High Blood Pressure
  - yes
  - no
- Heart Disease (heart murmur, hypertrophy, irregular heart beat, Marfan’s Syndrome, heart attack, stroke)
  - yes
  - no
- Diabetes
  - yes
  - no
- Non-accidental/sudden death in immediate family before age 50
  - yes
  - no

Please explain any YES responses below:
<p>| | | |</p>
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</table>

O. CONCUSSION HISTORY
Have you ever been diagnosed with a concussion?
- yes
- no
- unsure

If yes:
- Number of concussions __________________________
  |                          |                          |                          |
|                          |                          |                          |
- Date(s) of injury: _______________________________
  |                          |                          |                          |
|                          |                          |                          |
- How long did it take you to recover? _________________
  |                          |                          |                          |
|                          |                          |                          |
- Did you lose consciousness or get “knocked out”
  - yes
  - no

Did you have to go to the hospital?
- yes
- no
Voluntary Student Authorization to Disclose Health Information to Health Care Providers

I ____________________________ understand that the Bryn Athyn College Health Services Clinic ("Clinic") may wish to disclose my health information to a hospital or other health care provider so that I may receive care not provided in the Clinic. While this information may be disclosed under the Family Educational Rights to Privacy Act ("FERPA") without my authorization provided that it is disclosed solely for treatment purposes, I understand that there may be possible subsequent disclosures of my health information by a health care provider for reasons unrelated to treatment. Such disclosures may not occur without my authorization. In order to address this concern, the Clinic requests my authorization in the event of such disclosures. I understand that I am not required to sign this authorization and do so voluntarily. The Clinic will not condition any health care treatment on whether or not I authorize such disclosure.

I hereby authorize the health care providers at the Clinic to disclose my protected health and treatment-related information regarding any injury or illness I may experience while I am enrolled as a part-time or full-time student at the College to any hospital, health care facility and other health care professionals for the purpose of my receiving medical treatment, emergency care, hospitalization or other health care services not provided in the Clinic, as well as for non-treatment purposes a health care provider may have (e.g., billing). It is also my understanding that I may, at any time, advise the Clinic that I revoke this authorization or choose to limit instances of disclosure. It is my responsibility to so advise the Health Services Coordinator at the Clinic in writing. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization.

I understand that my health information is protected by the Clinic under FERPA as a “treatment record” if disclosed only for treatment purposes. Once the Clinic discloses my health information to a health care provider, my information continues to be protected by the College under FERPA and by the health care providers under the Health Insurance Portability and Accountability Act ("HIPAA"). Once disclosed for non-treatment purposes, my health information will continue to be protected by the College under FERPA as an “education record” and by the health care provider under HIPAA.

Unless sooner rescinded, this authorization expires once my enrollment at the College has concluded.

I hereby agree to the above.

Student Name (please print): ________________________________________________________________________________________

Student Signature: _________________________________________________________________________       Date: _______________

Parent/Guardian Signature: __________________________________________________________________      Date:________________

All services provided by the Student Health Center are strictly confidential. Medical Information cannot be released to family members without permission from the student unless the student is a threat to themself or others. Visit our website https://www.brynathyn.edu/health for more information about our services, or call our office at 267-502-6070.

Please inform us of any changes. Students should carry a copy of all insurance information on their person.

Student athletes are required to have medical insurance.
### Immunization Record Form

**Name:** ____________________________________________________________  **Start Term:** ____________  **Date of Birth:** ____________

**REQUIRED IMMUNIZATION INFORMATION-ALL STUDENTS BORN AFTER 1956 MUST PROVIDE THIS INFORMATION**

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given/Performed</th>
<th>Requirement</th>
</tr>
</thead>
</table>
| MMR      |                       | - 2 doses of MMR  
- Minimum of 4 weeks between doses  
- First dose given after 1st birthday  
- Second dose after age 4 |
| Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY |

<table>
<thead>
<tr>
<th>Individual Vaccines:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles</td>
</tr>
<tr>
<td>Mumps</td>
</tr>
<tr>
<td>Rubella</td>
</tr>
</tbody>
</table>

| Measles | Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY |
|----------|------------------|
| Mumps    | Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY |
| Rubella  | Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY |

<table>
<thead>
<tr>
<th>Positive blood test showing immunity</th>
<th>Attach laboratory report</th>
</tr>
</thead>
</table>
| Measles titer date  /  /  
MM DD YYYY | Result____________________ |
| Mumps titer date  /  /  
MM DD YYYY | Result____________________ |
| Rubella titer date  /  /  
MM DD YYYY | Result____________________ |

<table>
<thead>
<tr>
<th>Meningococcal (meningitis)</th>
<th>Check One</th>
</tr>
</thead>
<tbody>
<tr>
<td>/  /  YYYY</td>
<td>Menactra</td>
</tr>
<tr>
<td>/  /  YYYY</td>
<td>Menveo</td>
</tr>
</tbody>
</table>

- If initial dose is given under 16 years of age, two doses are required. If initial dose is given at 16 years of age or older, one dose is required.

<table>
<thead>
<tr>
<th>Varicella (chicken pox)</th>
<th>Date of Disease</th>
<th>Titer</th>
</tr>
</thead>
</table>
| Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY | OR  /  /  
MM DD YYYY | OR  /  /  
MM DD YYYY |

<table>
<thead>
<tr>
<th>Tdap within 10 years</th>
<th>Date of Disease</th>
<th>Titer</th>
</tr>
</thead>
</table>
|  /  /  YYYY | OR  /  /  
MM DD YYYY | OR  /  /  
MM DD YYYY |

<table>
<thead>
<tr>
<th>Hepatitis B or Twinrix (optional, but recommended)</th>
<th>Titer</th>
</tr>
</thead>
</table>
| Dose 1  /  /  
MM DD YYYY | Dose 2  /  /  
MM DD YYYY | Dose 3  /  /  
MM DD YYYY | OR  /  /  
MM DD YYYY |

**Practitioners Signature Required**

**Clinician Name (MD/NP/PA)**  **Clinician Signature**  **Clinician Phone Number**  **Date**

*Acceptable Documentation in Lieu of a Provider Signature includes a copy of an up-to-date high school or university immunization record, provider-signed personal immunization records, proof of current or previous active duty (DD214) status in the US Military or International W.H.O Yellow Book showing MMR dates.*
Health Services TB Questionnaire Part 1

Name:_______________________________________________________________ Start Term: ____________ Date of Birth: _____________

(LAST) (FIRST)                                         (MIDDLE)                                           (MONTH/YEAR)   (MONTH/DAY/YEAR)

REQUIRED! THIS SECTION MUST BE COMPLETED BY ALL STUDENTS, NOT YOUR DOCTOR.

1. Have you ever had close contact with persons with known or active TB (tuberculosis) disease?  □ Yes □ No

2. Were you born or have you lived or travelled for more than one month in one of the countries listed below with a high incidence of active TB (tuberculosis) disease?  □ Yes □ No

3. If yes, what country? (circle the country/ countries in the list below)

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

5. If yes, where? _____________________________________________________________

________________________________________________________________________

6. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?  □ Yes □ No

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

A - Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan
B - Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burma, Burundi
C - Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, Colombia, Comoros, Congo, Côte d’Ivoire
D - Dem Ppl’s Rep of Korea, Dem Rep of Congo, Djibouti, Dominican Republic
E - Ecuador, El Salvador, Equatorial Guinea Eritrea, Estonia, Ethiopia
F - Fiji
G - Gabon, Gambia, Georgia, Ghana, Guatemala, Guinea, Guinea-Bissau, Guyana
H - Haiti, Hong Kong, Honduras
I - India, Indonesia, Iran (Islamic Republic of), Iraq
K - Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan
L - Lao Ppl’s Democratic Rep, Latvia, Lesotho, Liberia, Libya, Lithuania
M - Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia, Mongolia, Morocco, Mozambique, Myanmar
N - Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue
P - Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal
Q - Qatar
R - Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda
S - Saint Vincent/Grenadines, Sao Tome and Principe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland
T - Taiwan, Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu
U - Uganda, Ukraine, United Rep of Tanzania, Uruguay, Uzbekistan
V - Vanuatu, Venezuela, Viet Nam
Y - Yemen
Z - Zambia, Zimbabwe
TB SYMPTOM CHECK - THIS SECTION MUST BE COMPLETED BY A HEALTH CARE PROVIDER.

Does the student have signs or symptoms of active pulmonary tuberculosis disease?  □ Yes  □ No

If yes, check below and proceed:

- Cough (especially if lasting for 3 weeks or longer)
- Coughing up blood (hemoptysis)
- Chest pain with or without sputum production
- Loss of appetite
- Unexplained weight loss
- Night sweats
- Fever

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, with “0”. The TST interpretation should be based on mm of induration as well as risk factors.**)

Date Given: ___________________  Date Read: ___________________

Result: __________ mm of induration  **Interpretation: positive __________ negative __________

IF YOU ANSWERED YES TO ANY OF THE QUESTIONS ON THE TB QUESTIONNAIRE, BRYN ATHYN COLLEGE REQUIRES YOU TO PROVIDE THE FOLLOWING:

Interferon-based Assay TB Blood Test
Quantiferon Gold Test or T-Spot

*Must be performed in the United States.

Det of blood test

Result

Attach laboratory report

If the result of the above test is POSITIVE, you must provide the following:

Chest X-ray

Date of X-ray

Result

Attach X-Ray report in English

Treatment for latent TB (check one)

□ Patient completed full course of treatment for latent TB.
   Medication and dates

□ Patient did not complete treatment for latent TB.
   Reason
**Student:** please submit this form to physician

**Physician** please review: Health History Questionnaire, Physical Form, Immunization and TB Forms.

Does the student have an illness/condition **NOT** listed in the history, for which treatment is required?  □ yes  □ no  
Please explain: __________________________________________________________
________________________________________________________________________

Is the student under treatment for Eating Disorder, Behavioral, OR Psychiatric Problems?  □ yes  □ no  
Please explain: __________________________________________________________
________________________________________________________________________

Does the student have Physical Disabilities OR Assisted Devices?  □ yes  □ no  
Please explain: __________________________________________________________
________________________________________________________________________

<table>
<thead>
<tr>
<th>CLINICAL EVALUATION</th>
<th>NORMAL</th>
<th>ABNORMAL (PLEASE EXPLAIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICAL:</strong></td>
<td></td>
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</tr>
<tr>
<td>BP_______  T_______  P_______  R_______</td>
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<tr>
<td>Height ______________________  Weight ______________</td>
<td></td>
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</tr>
<tr>
<td>Head, Face, Neck, and Scalp</td>
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<tr>
<td>Visual acuity and ophthalmic exam</td>
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<tr>
<td>Ears/Nose/Throat/Sinuses/Mouth</td>
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<tr>
<td>Lungs and Chest</td>
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<td>Heart</td>
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<td>Abdomen</td>
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<td>Skin</td>
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<td>Neurological</td>
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<td>G-U</td>
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<tr>
<td>Menstrual History</td>
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<tr>
<td><strong>MUSCULOSKELETAL:</strong></td>
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<tr>
<td>Neck</td>
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<tr>
<td>Back/Shoulder/Arm</td>
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<tr>
<td>Elbow/Forearm</td>
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<td>Wrist/Hand/Fingers</td>
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<tr>
<td>Hip/Thigh</td>
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<td>Knee</td>
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<tr>
<td>Leg/Ankle</td>
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<tr>
<td>Foot/Toes</td>
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<tr>
<td><strong>REQUIRED FOR ATHLETES:</strong></td>
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</tr>
<tr>
<td>Heart Murmur*</td>
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<tr>
<td>Femoral Pulses to exclude Aortic Coarctation</td>
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<td></td>
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<tr>
<td>Physical Stigmata or Marfan Syndrome</td>
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<tr>
<td>Bilateral, Brachial Artery BP, Sitting position**</td>
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</tbody>
</table>

*Should be done supine and standing (or Valsalva Maneuver) to identify (L) Ventricular outflow obstruction

**Preferably done in both arms
NCAA SPORTS/COLLEGE INTRAMURAL CLEARANCES

ATTENTION PROVIDERS!!

• For the student to tryout/ participate in NCAA Athletics/ Intramural Activities, the SIGNATURE SECTION MUST BE COMPLETED AND SIGNED by the Health Care Provider (Physician, PA-C OR Nurse Practitioner).

☐ CLEARED

☐ CLEARED, with recommendation(s) for further evaluation or treatment for:_______________________________________________________________

______________________________________________________________________________________

☐ NOT CLEARED for the following types of sports/intramurals (please check those that apply:)

☐ Contact  ☐ Non-Contact  ☐ Strenuous Activities

Due to ___________________________________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

Recommendation(s) / Referral(s) _____________________________________________________________

_________________________________________________________________________________________

_________________________________________________________________________________________

SIGNATURE SECTION

I certify that I have examined this student; that the above statements and health history are correct; and that I find the student is neither mentally nor physically disqualified by reason of communicable disease or any chronic or acute defect from successful performance as a college student at Bryn Athyn College, except as noted. Furthermore the student is also cleared/not cleared as stated above for participation in NCAA sports/ college intramural activities.

______________________________________________________  ____________________________________
Signature of Health Care Provider  License Number

_____________________________________________  ____________________     _____________________
Address  City  State    Zip Code   Phone        Fax

_____________________________________________________________ ____________________________________
Print Name of Health Care Provider  Date of CIPPE
Bryn Athyn College

Bryn Athyn College Health Services

2945 College Drive, Box 915, Bryn Athyn, PA 19009
Phone: 267-502-6070 | Fax: 267-502-6024
www.brynathyn.edu/health