WILSON COLLEGE

STUDENT HEALTH CENTER– STUDENT HEALTH INFORMATION

1015 Philadelphia Avenue, Chambersburg, Pa. 17201
MY.WILSON.EDU/HEALTH | nurse@wilson.edu

Instructions: This form becomes part of your permanent health file. All pages of the form must be completed. The completed form must be returned to the Student Health Center by the first day of classes.

STUDENT HEALTH INFORMATION

Year of Entry: _____

Name _____ Phone: (_____) _____
(First) (MI) (Last)

Address _____ S.S. #: _____
(Street)

_____ Birth date: _____ / _____ / _____
(City) (State) (Zip code)

Emergency Contact: _____ Relationship: _____

Address: _____

Home phone: (_____) _____ Work phone: (_____) _____

Insurance (required): Please attach a copy of the front and back of your current health insurance card

Family History: Please indicate if there is a history of any of the following in your family (including grandparents)

❍ Cancer ❍ Tuberculosis ❍ Diabetes ❍ Heart Problems ❍ High Blood Pressure ❍ Allergies ❍ Kidney problems

Medical History: Please answer all the questions and list the year of onset for all questions answered "yes."

	Yes	No		Yes	No		Yes	No
Asthma			Chemical Dependency			Meningitis		
Appendicitis			Diabetes			Malaria		
Arthritis			Eating Disorder			Pneumonia		
Allergies			Ear Problem			Reflux/GERD		
Back Problems			Eye Problem			Sinusitis		
Blood Disorder			Emotional Problem			STD/STI		
Blood Pressure Problem			Gall Bladder Problems			Thryoid Hypo/Hyper		
Cancer			Gum/Tooth Problems			Other		
Convulsion/ Seizure			Heart Problem					
Chicken Pox			Headache/Migraine					

Medications: Please list any medications you are taking, including over the counter, herbal, or prescribed medications. Please also note any special precautions, diet requirements, or interactions you may know of.

Medication	Dose/Frequency	Date started	Reason for taking

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Student's Name: _____ Birth date: _____ / _____ / _____

Physical Exam: To be completed and signed by your healthcare provider. Must be within past 12 months.

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ Resp. Rate: _____

Allergies:

❍ Drug Allergies: _____

❍ Food Allergies: _____

**This information is not shared with Wilson College Dining Services. If you would like Dining Services to be aware of your food allergy, please notify them directly at 717-264-4141, ext. 3200.*

❍ Other Allergies: _____

Are there any abnormalities of the following systems? *If "yes" please list.

	Yes	No		Yes	No
HEENT			Metabolic/Endocrine		
Respiratory			Neurovascular		
Cardiovascular			Neuropsychiatry		
GI			Integument/Skin		
GU			Other		
Musculoskeletal					

Comments:

_____

_____

_____

_____

On the basis of this History and Physical Examination: (To be completed by healthcare provider)

This student has a physical or emotional condition that would require ongoing health care.
Please specify: _____ ❍ Yes ❍ No

This student has a health or emotional condition that would affect her educational experience.
Please specify: _____ ❍ Yes ❍ No

This student has a health condition that would affect her participation in athletics.
Please specify: _____ ❍ Yes ❍ No

Examining Healthcare Provider's Signature: _____ Date: _____

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Student's Name: _____ Birth date: _____ / _____ / _____

Required Immunizations: To be completed by health care provider. Documentation must be in English.

Measles/Mumps/Rubella: Two doses required (at least 28 days apart after 12 months of age) or titer with report attached.*

Dose 1: _____/_____ / _____ Dose 2: _____/_____/ _____

OR

Positive Titer*: ❍ Measles _____/ ____/ _____ ❍ Mumps _____/_____/ _____ ❍ Rubella _____/ _____/_____

Polio: Primary series in childhood with IPV alone, OPV alone or IPV/OPV sequentially.

Completed Primary Series: _____/_____/ _____

Hepatitis B: Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B titer with report attached.*

Dose 1: _____/_____ / _____ Dose 2: _____/ _____/ _____ Dose 3: _____/_____/ _____

OR

Hepatitis B Titer*: _____/_____/ _____

Tdap: (Tetanus, Diphtheria, Pertussis) or booster with Td in last 10 years.

Tdap: _____/_____/_____ **OR** Td Booster: _____ / _____/ _____

Meningococcal: Required at college entry for students living in campus housing or must have signed the enclosed waiver that will be kept on file in your student health record.

- **If initial dose given age 13-15 yrs: booster dose at 16-18 yrs of age required.**
- **If initial dose given age ≥16 yrs, no booster dose required.**

Vaccine Date: _____ / _____/ _____ Booster (if indicated): _____ / _____/ _____

OR

❍ Waiver completed

Varicella: Born in the U.S. before 1980, a history of chicken pox, a positive varicella titer, or two doses of vaccine meets requirements.

1. History of Disease: ❍ Yes ❍ No **OR** Born in U.S. before 1980: ❍ Yes ❍ No
2. Immunization

   Dose 1: _____ / _____/_____

   Dose 2: _____ / _____/_____

   (given at least 12 weeks after 1st dose for ages 1-12 or at least 4 weeks after 1st dose if age 13 or older)

3. Positive Titer: _____/_____/ _____ **Attach report

Recommended but not required vaccines:

Influenza: annual immunization

HPV: series of three vaccines for females and males 11-26 years of age

Student's Name: _____ Birth date: _____ / _____ / _____

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Student's Name: _____ Birth date: _____ / _____ / _____

Part I. Tuberculosis (TB) Risk Assessment – Required of all students entering Wilson College, based upon guidelines of the American College Health Association and the U.S. Centers for Disease Control. For more information, see www.acha.org or www.cdc.gov/tb.

1. Has the student ever had a positive tuberculin skin test (TST) or Quantiferon TB test? ❍ Yes ❍ No
2. Does the student have a medical condition associated with increased risk of progressing to TB disease? ❍ Yes ❍ No
3. Is the student a member of a high risk group? ❍ Yes ❍ No
   - Had close contact with a known case of active tuberculosis
   - Use of illegal injected drugs
   - Immunosuppressed by medication or disease
   - Resident, employee, or volunteer in a nursing home, homeless shelter, correctional facility, or other healthcare facility
4. Has the student lived in one of the countries listed below and arrived in the U.S. within the past 5 years? ❍ Yes ❍ No

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2010. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata

If the answer is YES to any of the above questions, Wilson College requires that you receive TB testing.

If the answer to all of the above questions is NO, no further testing or further action is required.

PROCEED TO TUBERCULOSIS SCREENING, IF INDICATED

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Part II. Tuberculosis Screening—date of screening must be within past 6 months

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

1. Does the student have signs or symptoms of active tuberculosis disease?
    - Unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than 3 weeks
    - Cough with production of bloody sputum (hemoptysis)

If NO, proceed to tuberculosis testing. If YES, proceed with additional evaluation to exclude active tuberculosis disease, including tuberculosis testing, chest x-ray, and sputum evaluation, as indicated.

Tuberculosis Testing

Tuberculin Skin Test (TST): TST results should be recorded as actual millimeters (mm) of induration; if no induration, write "0".

Date placed: _____ / _____ / _____ Date read: _____/_____ / _____ Results: _____mm ❍ positive ❍ negative

Quantiferon Test (QFT): If previously received BCG vaccine, a blood test such as Quantiferon Gold or T-spot is the preferred test to indicate absence of TB.

Date obtained: _____ / _____ / _____ Results: ❍ positive ❍ negative ❍ indeterminate

If a current or previous TST or QFT is positive, a chest x-ray is required. *A copy must be provided in English.*

Date obtained: _____ / _____ / _____ Results: ❍ normal ❍ abnormal

INH Treatment: Date started: _____ x _____ months or ❍ declined

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_____ has had a complete history and physical examination on _____.
Name of Student/ D.O.B. Date

Health Care Provider Certification:

- I have performed a physical exam on the above name patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.
- I have reviewed the immunization and completed the tuberculosis risk assessment and/or tuberculosis screening

Provider Name _____ Phone: (_____) _____

Address _____
(Street)

_____
(City) (State) (Zipcode)

Healthcare Provider's Signature: _____ Date: _____

To be completed by student:

I hereby authorize the Wilson College nurse and/or authorized representatives to furnish medical care, including examinations, treatment, vaccinations and so forth. I hereby consent that the Wilson College nurse's office, athletic department, and/or the nursing department may share student health information, such as health physicals and immunization records, if deemed necessary, by mail, email or fax. I agree that I may be transferred to an accredited hospital or other health care center if deemed necessary.

Student's Signature: _____ Date: _____
(Parent/Guardian if student under 18)

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Student's Name: _____ Birth date: _____ / _____ / _____

Meningitis Information

College students living in campus housing are at an increased risk for meningococcal disease due to the close living quarters. Pennsylvania law **requires** that all incoming residential students must receive the meningitis vaccine or complete and sign a waiver declining the vaccine.

What is meningococcal disease?
Meningitis is a rare but dangerous and fatal bacterial infection. Even if treated quickly, the infection can cause death or permanent complications such as hearing loss, brain damage and amputations.

How is it spread?
The bacteria are spread through respiratory and throat secretions of an infected person (e.g. kissing). It is not spread by casual contact and usually is not as contagious as the common cold.

What are the symptoms?
Early symptoms usually include sudden onset of fever, severe headache and neck stiffness. Symptoms also can include nausea, vomiting, sensitivity to light and confusion. Symptoms usually appear 3-7 days after exposure. If you think you have these symptoms, call your doctor immediately.

Can meningitis be prevented?
Yes. Keeping vaccinations up to date is the best prevention of meningitis. A vaccine called Menactra protects against 4 out of 5 types of the disease. As with any vaccine, it is not 100% effective. If you have received the vaccine and think you may be experiencing the symptoms, call you doctor immediately.

For more information about meningococcal disease and the vaccine, visit www.cdc.gov/meningitis

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Please check the statement that applies, sign, and return with your student health information form.

❍ I have received the meningitis vaccine on: Date: _____ / _____ / _____

❍ I have read and understand the information about meningitis and **I DECLINE** the meningitis vaccine due to strong moral or religious conviction.

Student's Signature: _____ Date: _____
(Parent/Guardian if student under 18)

❍My physician has recommended that I do not receive the vaccine due to (***reasoning must be documented by physician***):

_____

_____

_____

Healthcare Provider's Signature: _____ Date: _____

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As a requirement of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), Wilson College is required to monitor a complete list of hypersensitive individuals that have clinically documented allergies to agents used for control of insects, rodents, and fungus in all areas of Wilson College. If you are a SPS participant and have a child with documented allergies to pesticides, please use this form to provide that information as well.

In addition, all such individuals must be notified prior to and before conducting spraying or application operations in that defined area.

If you indicate sensitivity, this form will be shared with the Director of Facilities Management and the Environmental Compliance Coordinator to ensure that you are contacted prior to a spraying or application.

FIRFA–Wilson College Pesticide Hypersensitivity Registry Individual Survey

Student's Name: _____

Email: _____ Phone: (_____) _____

Are you hypersensitive to any pesticides, fungicides or rodenticides? ❍ Yes ❍ No

If so, what are you hypersensitive to?

_____

_____

Is this hypersensitivity clinically documented? ❍ Yes ❍ No

If yes, please provide your medical documentation.