HEALTH PACKET INSTRUCTIONS

*All forms are to be returned to Student Health by August 3rd for the Fall Semester and December 11th for the Spring Semester*

All full time undergraduate, international, transfer and undergraduate residential and commuter students admitted to Chestnut Hill College are required to complete the Health Packet provided by Chestnut Hill College Student Health Center. The Student must complete the assigned sections, unless the student is under the age of 18 years old, then a parent or guardian is required to complete the forms. Failure to complete the Health Packet and the requirements could affect moving in to housing, athletic participation, or being able to be seen at Chestnut Hill College Student Health Center. For questions, please contact the Student Health Center @ 215.248.7111

THE HEALTH PACKET INCLUDES:

Pages 1 -3: Demographics, Emergency Contact, Health Insurance, Family History, Personal Medical History

 [ ]  Form is to be completed by ***student***

 [ ]  Please attach copy of health insurance/prescription & dental card – if available, for emergencies

Page 4: Required Meningitis Form

 [ ]  This form is completed by the ***student***

 [ ]  PA Law #955 requires students living in residence halls to receive the meningitis vaccine or sign a waiver of refusal.

 [ ]  Proof of Meningococcal Meningitis Conjugate Vaccine is required

 [ ]  THIS FORM MUST BE SUBMITTED PRIOR TO MOVING IN TO RESIDENCE HALL

Pages 5 - 7: Immunization and Tuberculosis Screening

 [ ]  This form must be completed and signed by your ***Health Care Provider (DO, MD, NP, or PA)*** or an official copy of the student’s current immunization record should be sent with the completed health packet.

 [ ]  A signed Doctor’s/Clergy note is required if you choose not to vaccinate for religious, medical or ethical reasons.

 [ ]  Students must complete the Tuberculosis screening section. Tuberculosis testing is only required for those students who report risk factors.

Page 8: Physical Examination Form

 [ ]  This form must be completed and signed by your ***Health Care Provider (DO, MD, NP or PA)***

 [ ]  Students whose annual physical is in August may submit their physical from the previous August

 [ ]  Transfer and International students will require a physical to be submitted

 [ ]  Student athletes may submit a copy of their sports physical

Page 9: General Consent, Acknowledgement and Authorization Form

 [ ]  This form must be completed by the ***student***, if he/she wants to be evaluated by the nurse/nurse practitioner in the Student Health Center for emergency care and/or elective visits, during his/her enrollment as a student. If the student is under the age of 18, a parent or guardian must complete this consent form.

***Please mail or email completed forms to Student Health***

***Mail: Chestnut Hill College***

***c/o Student Health Center***

***9601 Germantown Ave, Philadelphia, PA 19118***

***Email:*** ***studenthealth@chc.edu***

***THANK YOU and WELCOME TO CHESTNUT HILL COLLEGE!***

***For additional information on services provided, please refer to our website:***

<https://www.chc.edu/student-life/health-and-wellness>

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| STUDENT TO FILL OUT THIS INFORMATION |

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| STUDENT INFORMATION |

Name (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Preferred Name* (Last) (First) (Middle) (mm/dd/yyy)

Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Start Term: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Province/Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip/Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender Identity: [ ]  Woman [ ]  Man [ ]  Transgender (*please specify*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Select all that apply: [ ] Undergraduate [ ] International [ ] Transfer [ ] Student Athlete Resident Student: [ ]  Y [ ]  N

\*\*If student athlete, please refer to and complete health packet provided through Athletic Department\*\*

\*\*Is it okay for Health Services to contact you via your CHC email that we received this packet or to report missing items? [ ]  Y [ ]  N\*\*

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| EMERGENCY CONTACT INFORMATION |

Name (PRINT): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State/Province/Region: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip/Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| HEALTH INSURANCE |

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Please provide a copy of both sides of your health insurance/prescription card and dental insurance, if you have it, in case of emergencies. Students should also carry a copy of insurance information on them as well\*\**

 Page 1

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| STUDENT TO FILL OUT THIS INFORMATION |

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| FAMILY HISTORY |
| Biological Family Members | Age | Occupation | If Deceased (Cause of death) | Age of death | Any significant health issues; diabetes, cancer, heart disease, etc… |
| Mother |  |  |  |  |  |
| Father |  |  |  |  |  |
| Sibling M/F |  |  |  |  |  |
| Sibling M/F |  |  |  |  |  |
| Sibling M/F |  |  |  |  |  |
| Grandparent(s) |  |  |  |  |  |
| Grandparent(s) |  |  |  |  |  |
|  |  |  |  |  |  |

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| PERSONAL MEDICAL HISTORY – Please check “YES” or “NO” for every condition. If “YES”, please explain in comments on page 3. |
|  | YES | NO |  | YES | NO |  | YES | NO |
| ALLERGIES: |  |  | GASTROINTESTINAL: |  |  | HEENT: |  |  |
| - Food Allergies |  |  | - Chronic Inflammatory Bowel Disease |  |  | - Hearing loss |  |  |
| - Medication Allergies |  |  | - Acid Reflux/GERD |  |  | - Visual Disturbances |  |  |
| - Seasonal Allergies |  |  | - Celiac Disease |  |  | - Corrective Lens |  |  |
|  |  |  |  |  |  |  |  |  |
| CARDIOVASCULAR: |  |  | GENITOURINARY: |  |  | ENDOCRINE: |  |  |
| - Heart Conditions |  |  | - Frequent Urinary Tract Infections |  |  | - Diabetes |  |  |
| - Heart Murmur |  |  | - Kidney Stones |  |  | - Thyroid Disease |  |  |
| - High Blood Pressure |  |  | - Kidney Disease |  |  |  |  |  |
| - Low Blood Pressure |  |  |  |  |  | PSYCHOLOGICAL: |  |  |
| - Bleeding Disorder |  |  | RESPIRATORY: |  |  | - Alcohol/Drug Abuse |  |  |
| - Sickle Cell Disease/trait |  |  | - Asthma |  |  | - Anxiety |  |  |
| - Fainting/Syncope |  |  | - Chronic Cough |  |  | - Depression |  |  |
| - Family history of cardiac death before age 50 |  |  | - History of Tuberculosis (TB) |  |  | - Psychiatric Admission |  |  |
| - Marfan Syndrome |  |  |  |  |  | - Insomnia |  |  |
|  |  |  | DERMATOLOGY: |  |  | - Learning Disability |  |  |
| NEUROLOGICAL: |  |  | - History of MRSA |  |  | - ADD/ADHD |  |  |
| - History of Concussion |  |  | - Eczema |  |  | - Panic Disorder |  |  |
| - Cerebral Palsy |  |  | - Psoriasis  |  |  |  |  |  |
| - Migraines |  |  | - Urticaria/Hives |  |  | OTHER: |  |  |
| - Seizure disorder/ epilepsy |  |  |  |  |  | - Chicken Pox History |  |  |
| - Dizziness/fainting |  |  | MUSCULOSKELETAL: |  |  | - Hepatitis |  |  |
| - History of head injury |  |  | - Chronic back/joint pain |  |  | - HIV |  |  |
| - Autism Spectrum Disorder |  |  | - Chronic muscle weakness |  |  | - Mononucleosis (Mono) |  |  |
|  |  |  |  |  |  | - Cancer |  |  |

Page 2

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| STUDENT TO FILL OUT THIS INFORMATION |

COMMENTS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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ANY ILLNESSES NOT LISTED ABOVE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SURGERIES/HOSPITALIZATIONS (Reason/Year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALLERGIES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT MEDICATIONS (Name/Dosage/Frequency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* If you are a student who has any kind of disability, whether or not the disability is apparent, medical, learning, emotional, physical, and/or cognitive, and you need accommodations to increase your access the college environment, please contact the Disability Resource Center, located in St. Joseph Hall, room 240 by emailing the Director of the Center, Dr. Dolly Singley at disabilities@chc.edu or by calling 215-753-3655. Students can also visit the Disability Resource Center online at [www.chc.edu/disability](http://www.chc.edu/disability)

\*\*If you require specific housing accommodations, such as air conditioning for asthma, please go to the New Student tab on CHC portal to access the necessary “Housing Accommodation Form” that is required.

You may also contact CHC Housing at housing@chc.edu

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| For CHC Office Use: [ ]  Meningitis Form [ ]  Vaccines [ ]  Physical [ ]  Completed Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Incomplete: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

Page 3

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| STUDENT TO FILL OUT THIS INFORMATION |

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| REQUIRED MENINGITIS FORM |

Pennsylvania passed Senate Bill 955 which REQUIRES all students wishing to live in residential housing on a college campus to provide either proof of vaccination for meningitis (A,C,Y,W-135) or a signed waiver requesting exemption after having received information on the risks associated with meningococcal disease and the availability and effectiveness of the vaccine. MOVING IN OR RESIDING IN STUDENT HOUSING IS PROHIBITED UNTIL THIS FORM IS COMPLETED. THERE WILL BE NO EXCEPTIONS.

* **What is meningococcal meningitis?** Meningitis is rare, but when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities such as hearing loss, brain damage, seizures, limb amputation and even death.
* **How is it spread?** Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.
* **What are the symptoms?** Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.
* **Who is at risk?** Certain college students, particularly those who live in dormitories or residence halls, have been found to have an increased risk for meningococcal meningitis. Other undergraduates may also consider vaccination to reduce their risk for the disease.
* **Can meningitis be prevented?** Yes, a safe and effective vaccine is available. The vaccine is 85% to 100% effective on preventing four kinds of bacteria (serogroups A, C, Y, W-135) that cause the disease in the United States. At least 70% of all cases of meningococcal disease in college students are vaccine preventable. After vaccination, immunity develops within 10 to 14 days and remains effective for 3 to 5 years. The vaccine is safe, with mild and infrequent side effects, such as fever, redness and pain at the injection site lasting for a couple of days. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals. It does not protect against viral meningitis.

PLEASE SELECT A BOX BELOW

[ ]  RECEIVED the Meningococcal Meningitis Conjugate Vaccine (A,C,Y,W-135)

 [ ]  If initial dose given prior to 16th birthday, 2 doses are required

 [ ]  If initial dose given at 16 years of age or older, 1 dose is required

|  |  |  |
| --- | --- | --- |
| DOSE # | VACCINE NAME: | DATE (MM/DD/YYY) |
| Dose 1 |  |  |
| Dose 2 |  |  |

*PLEASE ATTACH IMMUNIZATION RECORD OR PROOF OF VACCINATION*

[ ]  DECLINE to receive the Meningitis vaccine(s)-COMPLETION OF WAIVER BELOW IS REQUIRED

CHESTNUT HILL COLLEGE MENINGOCOCCAL WAIVER:

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, received and reviewed the information provided by Chestnut Hill College regarding meningococcal disease. I am fully aware of the risks associated with meningococcal disease, and of the availability and effectiveness of the vaccinations against the disease. I knowingly decided NOT to receive a vaccination against meningococcal disease for religious, medical or other reasons. I understand that in declining this vaccine, I continue to be at risk for this disease.

Student Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Note to Residents: Students under the age of 18 need a parent/guardian signature if they did not receive vaccine and plan to live on campus.*

Page 4

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| HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION |

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| REQUIRED IMMUNIZATION HISTORY |

*To satisfy the* ***required*** *immunizations, you must have received the vaccine(s)* ***or*** *provide titer results, which is blood testing that shows immunity.*

*Must be completed and signed by a health care provider* ***or*** *attach a copy of an immunization record (must include all required immunizations listed below).*

 *If the required vaccines are contraindicated due to medical or religious reasons, you must attach documentation signed by your health care provider or clergy. This is in addition to the meningitis waiver.*

|  |  |  |
| --- | --- | --- |
| **REQUIRED** VACCINES(Please complete or attach copy of immunization) | Doses(mm/dd/yyyy) | TITER: DATE & RESULTS(If negative, will need vaccine) |
| \*\*Meningococcal Vaccine or waiver\*\*(Menactra, Menveo, MCV4)**Required if living in residence halls**  | 1. | 2. | [ ]  Not living on campus |  |
| MMR (Measles, Mumps, Rubella) | 1. | 2. |  |  |
| Varicella (Chicken Pox) | 1. | 2. |  |  |
| Tdap (Tetanus, Diphtheria, Pertussis) or Td Within last 10 years | 1. |  |  |  |
| Hepatitis B | 1. | 2. | 3. |  |

|  |  |  |
| --- | --- | --- |
| RECOMMENDED VACCINES(Please complete or attach copy of immunization) | DOSES(mm/dd/yyy) | TITER: DATE & RESULTS(If negative, will need vaccine) |
| Polio (Date Series Completed) | 1. |  |  |  |
| Hepatitis A | 1. | 2. |  |  |
| HPV | 1. | 2. | 3. |  |
| Meningitis B (Bexsero, Trumenba) \*\***Note: this is NOT the same** **as the required Meningitis noted above** | 1. | 2. | 3. |  |

SIGNATURE OF PRACTIONER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Page 5

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| TUBERCULOSIS SCREENING (**STUDENT** please review and answer all questions) |

|  |  |  |
| --- | --- | --- |
| 1. Have you ever had close contact with persons known or suspected to have active TB disease? | q Yes | q No |
| 2. Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below) | q Yes | q No |
| AfghanistanAlgeriaAngolaAnguillaArgentinaArmeniaAzerbaijanBangladeshBelarusBelizeBeninBhutanBolivia (Plurinational State of)Bosnia and HerzegovinaBotswanaBrazilBrunei DarussalamBulgariaBurkina FasoBurundiCabo VerdeCambodiaCameroonCentral African RepublicChadChinaChina, Hong Kong SARChina, Macao SARColombia | Comoros CongoCôte d'IvoireDemocratic People's Republic of KoreaDemocratic Republic of the CongoDjiboutiDominican RepublicEcuadorEl SalvadorEquatorial GuineaEritreaEthiopiaFiji GabonGambiaGeorgiaGhanaGreenlandGuamGuatemalaGuineaGuinea-BissauGuyanaHaitiHondurasIndiaIndonesia | Iraq KazakhstanKenyaKiribatiKuwaitKyrgyzstanLao People's Democratic RepublicLatviaLesothoLiberiaLibyaLithuaniaMadagascarMalawiMalaysiaMaldivesMaliMarshall IslandsMauritaniaMauritiusMexicoMicronesia (Federated  States of)MongoliaMontenegroMoroccoMozambiqueMyanmar | NamibiaNauruNepalNew CaledoniaNicaragua NigerNigeriaNorthern Mariana IslandsPakistanPalauPanamaPapua New GuineaParaguayPeruPhilippinesPortugalQatarRepublic of KoreaRepublic of MoldovaRomaniaRussian FederationRwandaSao Tome and PrincipeSenegalSerbiaSierra Leone SingaporeSolomon Islands | Somalia South AfricaSouth SudanSri LankaSudanSurinameSwazilandSyrian Arab RepublicTajikistanTanzania (United Republic of)ThailandTimor-LesteTogoTunisiaTurkmenistanTuvaluUgandaUkraineUruguayUzbekistanVanuatuVenezuela (Bolivarian Republic of)Viet NamYemenZambiaZimbabwe |
| *Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to* [*http://www.who.int/tb/country/en/*](http://www.who.int/tb/country/en/). |
| 3. Have you had frequent or prolonged visits\* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above) | q Yes | q No |
| 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)? | q Yes | q No |
|  5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? | q Yes | q No |
| 6. 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 abusing drugs or alcohol?**Continued on next page:** | q Yes | q No |

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| TUBERCULOSIS SCREENING CONTINUED: |

**If the answer is YES to any of the above questions**, Chestnut Hill College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester.

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

*\* The significance of the travel exposure should be discussed with a health care provider and evaluated.*

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| TUBERCULOSIS TEST (Only REQUIRED if you checked “YES” in the screening) To be done by **Health Care** **Provider**  |
| DATE APPLIED | ARM | METHOD | ANTIGEN | MANUFACTURER | SIGNATURE |
|  |  |  |  |  |  |
| DATE READ | RESULTS | INDURATION(MM) | SIGNATURE |
|  |  |  |  |

Chest X-Ray (Attach copy of report): Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IGRA (Attach copy of report): Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If significant reaction was reported, the provider must include a letter that the student is free from TB or under adequate TB treatment.*

Provider’s Name/Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 7

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| HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION |

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| REQUIRED PHYSICAL EXAMINATION |

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Physical:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To the practitioner:

Please review the student’s history, complete this form and comment on any positive answers. Thank you.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| HRBP |   /  | HEIGHT |  | WEIGHT |  |
| VISUAL ACUITY UNCORRECTED CORRECTED L 20/ R 20/ L 20/ R 20/ |
|  | Normal | Abnormal | Please Comment on all abnormal (use space below if needed) |
| Head, Ears, Nose & Throat |  |  |  |
| Eyes |  |  |  |
| Respiratory |  |  |  |
| Cardiovascular |  |  |  |
| Gastrointestinal |  |  |  |
| Genitourinary |  |  |  |
| Musculoskeletal |  |  |  |
| Metabolic/Endocrine |  |  |  |
| Skin |  |  |  |
| Psychiatric |  |  |  |
| Neurological |  |  |  |
| Comments: |

Practitioner Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *City State Zip*

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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|  |
| --- |
| STUDENT TO FILL OUT THIS FORM |

General Consent, Acknowledgement and Authorization Form

**Consent to Treatment**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(student name) consent to evaluation and/or treatment of the condition for which I, or my dependent, has come to the Student Health Center at Chestnut Hill College with, and authorize the licensed Nurse Practitioner/Registered Nurse(s) employed by Chestnut Hill College to provide such evaluation and/or treatment. I consent to all physical examinations, injections, collection of laboratory specimens, venipuncture and all other testing deemed necessary during a visit with the Student Health Centers’ providers. I understand and acknowledge that no guarantees have been made to me regarding the likelihood of success or outcomes of any treatment, evaluation, diagnosis, or test performed at the Student Health Center of Chestnut Hill College. I understand that the services will be provided by a licensed Nurse Practitioner/Registered Nurse(s). I agree to ask any and all questions before injections given, laboratory specimens collected, and/or appropriate testing is performed. I acknowledge and agree that this consent will be applicable to all visits, emergency care, or episodes and treatment by the Student Health Center at Chestnut Hill College.

**Confidentiality/Notice of Privacy Practice**

We are required by law to maintain the privacy and security of your protected health information. All services provided by the Student Health Center at Chestnut Hill College are confidential, and are not released to a third party without written permission. Ethical and legal guidelines permit disclosure when a student is in a critical condition or there is a threat to self or others. We will not use or share your information other than described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(student name) acknowledge that I have had the opportunity to read and review the information pertaining to the Student Health Centers’ Notice of Privacy Practice.

**Acknowledgement of Financial Responsibility**

Services provided by the Student Health Center at Chestnut Hill College are free to students with some exceptions. Any laboratory specimens (titers, urine cultures, throat cultures, etc.) that need to be sent to an outside lab (LabCorp or MedLabs) will be charged to the student’s health insurance. Some prescription medication is available in the Student Health Center for a nominal fee. Any additional prescription medication that may be ordered, will be charged to the student’s health insurance. Any and all referrals, additional testing and follow up visits through another provider or organization will be charged to the student’s health insurance. If the student does not have health insurance, all acquired costs are billed to the student, and are the financial responsibility of the student.

I understand that I am responsible for paying the cost of any services at the time services are provided, and responsible for making payments in full for any and all services. Chestnut Hill Colleges’ Student Health Center is not responsible for obtaining reimbursement on my behalf, or assisting me in obtaining reimbursement from any sources. I understand that I am responsible for any charges that I incur by choosing to utilize the Student Health Center at Chestnut Hill College.

By signing below, I confirm my understanding of the above information and my consent to the above disclosures. You must be over the legal age of 18 years old, to sign this form of consent.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If signed by anyone other than the student, check the box that describes the relationship to the student.*

 [ ]  Parent [ ]  Guardian [ ]  Healthcare Agent [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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