Chestnut Hill College
Student Health Center
9601 Germantown Avenue
Philadelphia, PA 19118
Phone: 215-248-7111/Fax: 215-753-3663
Email: studenthealth@chc.edu

HEALTH PACKET INSTRUCTIONS

All forms are to be returned to Student Health by August 1st for the Fall Semester and December 15th for the Spring Semester

All full time undergraduate, international, transfer and undergraduate residential 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. If you are a student-athlete, do NOT complete this packet, please complete the *Required Medical Forms for Athletic Participation* located in the Student-Athlete Information section of the New Student Guide. 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 at 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 & 6: 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 7: 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 8: 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

STUDENT TO FILL OUT THIS INFORMATION

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

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: ______________________________

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

Rev 11/2017

STUDENT TO FILL OUT THIS INFORMATION

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)					

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		

STUDENT TO FILL OUT THIS INFORMATION

COMMENTS____
____
____

ANY ILLNESSES NOT LISTED ABOVE: ____
____

SURGERIES/HOSPITALIZATIONS (Reason/Year):____
____

ALLERGIES: ____

CURRENT MEDICATIONS (Name/Dosage/Frequency):____
____
____

ARE THERE ANY DISABILITES OR AREAS OF CONCERN THAT YOU WOULD LIKE US TO KNOW ABOUT: ____________
____
____
____
____

Student Signature: ____ Date: __________________

For CHC Office Use: ☐ Meningitis Form ☐ Vaccines ☐ Physical ☐ Completed Date:_______________
☐ Incomplete: ____

STUDENT TO FILL OUT THIS INFORMATION

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 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.

HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION

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/yyy)			TITER: DATE & RESULTS (If negative, will need vaccine)
Meningococcal Vaccine or waiver** **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.	

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? ❑ Yes ❑ 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) ❑ Yes ❑ No

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

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/.

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) ❑ Yes ❑ 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)? ❑ Yes ❑ No

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

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.*

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:______________

Rev 11/2017

HEALTH CARE PROVIDER TO FILL OUT THIS INFORMATION

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.

BP	/	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:

SIGNATURE OF PRACTIONER:

Practitioner Name: _____________________________________Signature: ________________________________

Address: ____

City *State* *Zip*

Phone: ___________________________________ Date: _______________________________

Rev 11/2017

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 ____________________________________