



Instructions and Information:

1. The primary purpose of these forms is to provide a means of identifying and attending to students with medical problems or special needs and to assure that immunizations are current, thereby reducing public health risks on campus.
2. **Completion of this form (all four pages) is mandatory for all new full-time and all transfer students. Please submit forms to Appel Health Services staff at Beginnings or mail forms directly to Appel Health Services by July 1. For spring admission forms are due by December 1.**
3. Information on this form will not affect admission status. It is confidential and for Health Service and hospital emergency care only.

LAST NAME	FIRST NAME	MIDDLE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
HOME ADDRESS (NUMBER AND STREET)	CITY OR TOWN	STATE	ZIP CODE	TELEPHONE NUMBER
NAME & RELATIONSHIP TO BE NOTIFIED IN CASE OF EMERGENCY		(AREA CODE) HOME TELEPHONE NUMBER	(AREA CODE) BUSINESS TELEPHONE NUMBER	

Franklin & Marshall College has a mandatory health insurance requirement.

I already have insurance that will cover me at College. Providing a copy of both sides of insurance card is required

Insurance Company Name _____

Name of Insured _____ Insured's Date of Birth _____

I plan to enroll in the College sponsored policy.

REPORT OF MEDICAL HISTORY
 PLEASE COMPLETE THIS BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION

1. List any illness or medical condition for which you are being treated currently.

CONDITION	YEAR DIAGNOSED	TREATMENT

2. List any operations or hospitalizations you have had.

3. List all medications you are now taking (include over the counter, supplements, birth control pills, allergy serum, psychotropics)

NAME OF MEDICATION	DOSE	HOW OFTEN

4. List your ALLERGIES to:

Reaction:

Medications _____

Environment/Food/Insects: _____

MEDICAL HISTORY—Check all applicable items, whether current or past problem. Give details in the space provided below.

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Congenital Defects | <input type="checkbox"/> Heart defects | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Orthopedic problem | <input type="checkbox"/> Chickenpox |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Irritable bowel syndrome | <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Treatment by psychologist, psychiatrist, or counselor |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Ulcer disease | <input type="checkbox"/> Diabetes mellitus | <input type="checkbox"/> Menstrual disorder |
| <input type="checkbox"/> Hearing defects | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Endocrine problem | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Serious eye defects | <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Smoker | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Drug problem | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Neurologic disorder | <input type="checkbox"/> Alcohol problem | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Headaches | <input type="checkbox"/> Learning disability/ADD | |

Details of above items checked: _____

LAST NAME

FIRST NAME

MIDDLE INITIAL

DOB

FAMILY HISTORY

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					

Have any of your relatives ever had any of the following?

	Yes	No	Relationship
Cancer			
Diabetes			
Heart Disease			
Hypercholesterolemia			
Hypertension			
Kidney Disease			
Lung Disease			
Tuberculosis			
Ulcer Disease			

REPORT OF PHYSICAL EXAMINATION (current within previous 12 months)

TO THE EXAMINING PRACTITIONER: Please review the student's history and complete this report, the Tuberculosis Screening on page 3, and the Immunization Record on page 4.

BP

Pulse

Vision

R ^{20/}L ^{20/}

Hgt. Wgt.

Baseline peak flow (if any Hx of Asthma) _____

Laboratory studies highly recommended.

Urinalysis Glu/Pro/Blood Micro

Hgb. or Hct.

Cholesterol

Are there abnormalities on examination of the following systems? Use additional sheet if needed. Please describe fully if abnormal.

No Yes

	No	Yes
1. Head, Ears, Eyes, Nose, Throat		
2. Respiratory		
3. Cardiovascular		
4. Gastrointestinal		
5. Genitourinary (including hernia)		
6. Musculoskeletal		
7. Endocrine		
8. Neurologic		
9. Psychiatric		
10. Skin		

1. Is there loss or seriously impaired function of any paired organ? ___ No ___ Yes

2. Have you any general comments or recommendations regarding the care of this student? ___ No ___ Yes

3. Is the student now under treatment for any medical or emotional condition? ___ No ___ Yes

4. Please comment on any unresolved orthopedic injury, previous head or neck injury, heart murmur or irregular heart rate.

ON THE BASIS OF THIS EXAMINATION, I FIND THIS STUDENT MEDICALLY SUITABLE TO PARTICIPATE IN ANY VARSITY, CLUB, AND/OR INTRAMURAL SPORT ACTIVITY AT F&M.

___ YES ___ NO (if no, explain)

STUDENT NAME _____

DOB _____

TUBERCULOSIS (TB) RISK ASSESSMENT

Persons with any of the following risk factors are candidates for either Interferon Gamma Release Assay (IGRA) or Mantoux tuberculin skin test (TST), unless a previous positive test had been documented, in which case a recent chest x-ray (within 3 months) needs to be provided.

Recent close contact with someone with infectious TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ transplant recipient	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- α antagonist)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of illicit drug use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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

1. Does the student have signs or symptoms of active tuberculosis disease? Yes No

If No, proceed to 2 or 3. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

Date obtained: / / (specify method) QFT-G QFT-GIT other
M D Y

Result: negative positive indeterminate

3. Mantoux Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0")

Date given: / / Date read: / /
M D Y M D Y

Result: mm of induration

4. Chest x-ray: (Required if IGRA or TST is positive)

Date of chest x-ray: / / Result: normal abnormal
M D Y

5. Treatment with INH Yes No

Date started: / / Date completed: / /
M D M D

The College reserves the right to require further testing for Tuberculosis screening.

The American College Health Association has published guidelines on TB screening of college students that are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information visit (www.acha.org/info_resources/tb_statement.pdf) or refer to CDC's Q&A about TB at www.cdcnpi.org/scripts/tb/faq.asp#2

LAST NAME

FIRST NAME

MIDDLE INITIAL

DOB

IMMUNIZATION RECORD

IMMUNIZATION RECORD (below) and TB RISK ASSESSMENT (page 3) TO BE COMPLETED BY YOUR HEALTH CARE PRACTITIONER WHO PERFORMS THE PHYSICAL (Dates must include month and year.)

Required Immunizations:

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12 months or later #1 ___/___/___
M Y
2. Dose 2 given at least 28 days after first dose..... #2 ___/___/___
M Y

B. Tetanus-Diphtheria (primary series with DTaP, DTP, DT, or Td and booster with Td or Tdap in the last 10 years meets requirement.)

1. Completed primary series (three doses if first dose >=12 months of age)..... ___/___/___
M Y
(four doses if first dose <12 months of age) ___/___/___
M Y
2. Td booster within past 10 years..... Td ___/___/___
M Y
Tdap ___/___/___
M Y
3. A booster dose of Tdap may be given if 2 years since last Td to protect against pertussis ___/___/___
M Y

C. Polio (Primary series in childhood meets requirement.)

Completed primary series..... ___/___/___
M Y

D. Meningococcal

Required by Pennsylvania state law for students who live in College owned housing. See enclosed information sheet and waiver below to sign if you choose not to be vaccinated.

Specify type: conjugate is preferred (Menactra™) ___/___/___
M Y
Menomune® is an acceptable alternative if conjugate is not available ___/___/___
M Y

WAIVER

I have read and understand the information you provided about the risks of meningococcal disease and the availability and effectiveness of the vaccine, but, for religious or other reasons, I decline the meningococcal vaccine at this time. (Parental signature required if under age 18.)

SIGNATURE OF STUDENT IF 18 OR OLDER

DATE

PARENT SIGNATURE IF STUDENT YOUNGER THAN 18

DATE

E. Hepatitis B (minimum of 2 doses required) Dose #1 ___/___/___ Dose #2 ___/___/___ Dose #3 ___/___/___
M Y M Y M Y

Recommended if no history of disease:

Recommended (females):

A. Varicella Dose #1 ___/___/___ Dose #2 ___/___/___ Human Papillomavirus Vaccine
M Y M Y
B. Hepatitis A Dose #1 ___/___/___ Dose #2 ___/___/___
M Y M Y
Dose #3 ___/___/___
M Y

See website for www.acha.org/info_resources/guidelines.cfm

MD/NP/PA SIGNATURE _____ DATE _____
(Signature acknowledges review of history, verification of immunization record and tuberculosis screening, and performance of physical.)

ADDRESS _____

PRINT LAST NAME _____

PHONE _____

FAX _____

Return all information to:
DIRECTOR, APPEL HEALTH SERVICES
Franklin & Marshall College
P.O. Box 3003
Lancaster, PA 17604-3003
Phone: 717-291-4082
FAX: 717-291-4277
Marianne.Kelly@fandm.edu
www.fandm.edu/healthservices.xml