BRYN ATHYN COLLEGE®
OF THE
NEW CHURCH

Student Health Center Health Information Packet

For All Students

BRYN ATHYN COLLEGE HEALTH SERVICES | BOX 915, 900 CAMPUS DRIVE, BRYN ATHYN PA 19009

BRYN ATHYN COLLEGE®
OF THE
NEW CHURCH

Health Information Instructions and Checklist

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Packet is required of all students

Packet Checklist

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

Instructions

Once the Health Information Packet has been reviewed and completed, it should be mailed 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 and Graduate programming.

Mail to: Director of Health and Wellness
Bryn Athyn College, PO Box 915
900 Campus Drive, Bryn Athyn, PA 19009

- o **Keep a COPY** of this form, and any attachments for your records
- o Submission of this form is MANDATORY for all BAC students

Questions? Call 267-502-6070 or email HealthCenter@brynathyn.edu

About the Student Health Center

The Student Health Center is the primary health care facility for the College. The purpose is to provide 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.

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

BRYN ATHYN COLLEGE®
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Student Information Page

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.

Student Information

NAME:_____

ADDRESS:_____

CITY:_____

STATE:_____

HOME PHONE NUMBER: _____

STUDENT CELL PHONE NUMBER: _____

BIRTH DATE: _____

SEX: _____

COUNTRY RAISED IN: _____

COUNTRY OF BIRTH: _____

CHECK ALL THAT APPLY:

- o Undergraduate o Graduate o Theological School
- o Resident o Commuter o International o Online
- o Full Time o Part Time o Auditor o Transfer
- o Freshmen o Sophomore o o Junior o Senior

Emergency Contact

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____

CITY:_____

STATE:_____ ZIP:_____ COUNTRY:_____

HOME PHONE NUMBER: _____

WORK PHONE NUMBER: _____

CELL PHONE NUMBER: _____

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

Health History Questionnaire Part 2

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

MEDICATIONS (Prescription, non-prescription, vitamins, herbal, etc.)

Medication	Dose	Times Taken Per Day

If you do not take any medications, check here

ALLERGIES/REACTIONS

Medicine/Food/Agent	Reactions/ Side Effect

If you have no known allergies, check here

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

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

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

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

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

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

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

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

H. MEN'S HEALTH
- o Testicular Problems

I. WOMEN'S HEALTH
- o Irregular Menses
- o Painful Menses
- o Last menstrual period_____

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Health History Questionnaire Part 2

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please fill out this page and take to physical | Physician: please review during physical

J. PSYCHOLOGICAL OR SOCIAL

- o Alcohol/ Drug Abuse Problems
- o Anxiety
- o Depression
- o Eating Disorder
- o Panic Attack
- o Insomnia
- o ADD/ ADHD
- o Learning Disability
- o Suicide Attempt
- o Psychiatric Admission

K. ILLNESSES NOT LISTED ABOVE: _____

_____

_____

_____

L. SURGERIES AND HOSPITALIZATIONS

Dates: Specify reason:

_____

_____

_____

M. ORTHOPEDIC HISTORY - Have You Ever Had an Injury to:

- o Shoulder (describe): _____
- o Elbow/Wrist/Arm/Hand (describe): _____
- o Lower Leg (describe): _____
- o Knee (describe): _____
- o Ankle/Foot (describe): _____
- o Hip/Groin (describe): _____
- o Back/Ribs (describe): _____
- o Neck (describe): _____
- o Physical Disability (describe): _____

N. FAMILY HISTORY

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

High Blood Pressure

o yes o no

Heart Disease (heart murmur, hypertrophy, irregular heartbeat, Marfan's Syndrome, heart attack, stroke)

o yes o no

Diabetes

o yes o no

Non-accidental/sudden death in immediate family before age 50

o yes o no

Please explain any **YES** responses below: _____

_____

_____

_____

O. CONCUSSION HISTORY

Have you ever been diagnosed with a concussion?

o yes o no o 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"

o yes o no

Did you have to go to the hospital?

o yes o no

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

HIPPA/FERPA/ Insurance Form

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Patient Privacy Rights

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.

Students to fill out this information

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: _____
(IF UNDER 18 YEARS OF AGE)

Health Insurance Request

All students are **required** to have health insurance. A copy of their insurance card is kept on file to help assist the health center in guiding care. It is recommended that students carry their health insurance cards at all times. Please attach a copy of your health insurance card (front and back) and a copy of your dental insurance card if you have one. This information will be used by health services during an emergency situation.

- ○ **I have attached a copy of my insurance cards front and back (must be a current non-expired card). A copy of your insurance card can be obtained on your insurance carrier's website.**
- ○ **I do not have health insurance and would like to explore my insurance options.**

It is required that international students purchase US insurance policies or policies that are active in the US. If you do not provide a copy of your health insurance, you may be subject to registration and housing holds as well as fines. Please let us know if you do not have health insurance we would be happy in assisting locate information on finding affordable insurance policies. The college does not have a policy that we automatically enroll students in.

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.

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

Immunization Record Form

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

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

Vaccines	Dates Given/Performed	Requirement
MMR	Dose 1_____/_____/_____ (MM DD YYYY) Dose 2_____/_____/_____ (MM DD YYYY)	• 2 doses of MMR • Minimum of 4 weeks between doses • First dose given after 1st birthday • Second dose after age 4
OR	**Measles**	**OR**
Individual Vaccines: Measles Mumps Rubella	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)	• 2 doses of each individual component (2 measles, 2 mumps, 2 rubella) • Minimum of 4 weeks between doses • First dose given after 1st birthday • The second dose is recommended after age 4
OR	**Attach laboratory report**	**OR**
Positive blood test showing immunity	Measles titer date _____/_____/_____ (MM DD YYYY) Result_____ Mumps titer date _____/_____/_____ (MM DD YYYY) Result_____ Rubella titer date _____/_____/_____ (MM DD YYYY) Result_____	• Positive titers
Meningococcal (meningitis) Group A	_____/_____/_____ (MM DD YYYY) _____/_____/_____ (MM DD YYYY) **Check One** o Menactra o Menveo o MenQuadfi	• 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.
Meningococcal Group B	_____/_____/_____ (MM DD YYYY) _____/_____/_____ (MM DD YYYY) **Check One** o Bexsero (MenB-4C) o Trumenba (MenB-FHbp)	• 2 doses at least six months apart • Pennsylvania 35 P.S. 633.3 requires proof of Meningococca vaccination for residential living or the signing of an informed waiver

Varicella (chicken pox)	Dose 1_____/_____/_____ (MM DD YYYY)	Dose 2_____/_____/_____ (MM DD YYYY)	**Date of Disease** OR _____/_____/_____ (MM DD YYYY)	**Titer** OR _____/_____/_____ (MM DD YYYY)
Tdap within 10 years	_____/_____/_____ (MM DD YYYY)			
Hepatitis B or Twinrix (optional, but recommended)	Dose 1_____/_____/_____ (MM DD YYYY)	Dose 2_____/_____/_____ (MM DD YYYY)	Dose 3_____/_____/_____ (MM DD YYYY)	**Titer** 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.

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

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?	o Yes o 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?	o Yes o 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)?	o Yes o 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?	o Yes o 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?	o Yes o 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, Greenland, 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, Mariana Islands
N - Northern Marcana Islands Nicaragua, Niger, Nigeria, Niue, Namibia, Nauru, Nepal,
P - Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal
Q - Qatar
R - Republic of Moldova, Romania, Russian Federation, Rwanda Republic of Korea
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

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

Health Services TB Questionnaire Part 2

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

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? o Yes o No

If yes, check below and proceed:

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

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 induraction, 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 _____
(MONTH/DAY/YEAR) (MONTH/DAY/YEAR)

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.	**Date of blood test** ____ /____/_____ MM DD YYYY	**Attach laboratory report** Result _____

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

Chest X-ray	**Date of X-ray** ____ /____/_____ MM DD YYYY	**Attach X-Ray report in English** Result _____

Treatment for latent TB (check one)

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

o Patient did not complete treatment for latent TB.
Reason _____
_____

BRYN ATHYN COLLEGE® OF THE NEW CHURCH

Physical Form Part 1

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

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? o yes o no
Please explain: _____

Is the student under treatment for Eating Disorder, Behavioral, OR Psychiatric Problems? o yes o no
Please explain: _____

Does the student have Physical Disabilities OR Assisted Devices? o yes o no
Please explain: _____

CLINICAL EVALUATION	NORMAL	ABNORMAL (*PLEASE EXPLAIN*)
MEDICAL:		
BP_____T_____P_____R_____		
Height_____Weight_____		
Head, Face, Neck, and Scalp		
Visual acuity and ophthalmic exam		
Ears/Nose/Throat/Sinuses/Mouth		
Lungs and Chest		
Heart		
Abdomen		
Skin		
Neurological		
G-U		
Menstrual History		
MUSCULOSKELETAL:		
Neck		
Back/Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		
REQUIRED FOR ATHLETES:		
Heart Murmur*		
Femoral Pulses to exclude Aortic Coarctation		
Physical Stigmata or Marfan Syndrome		
Bilateral, Brachial Artery BP, Sitting position**		

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

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Physical Form Part 2

Name:_____ Start Term:_____ Date of Birth: _____
(LAST) (FIRST) (MIDDLE) (MONTH/YEAR) (MONTH/DAY/YEAR)

Student: please submit this form to physician

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

COLLEGE INTRAMURAL CLEARANCES ATTENTION PROVIDERS!!

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

o **CLEARED**

o **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____
_____
_____

o **NOT CLEARED** for the following types of intramurals (please check those that apply:)

o Contact o Non-Contact o Strenuous Activities

Due to _____
_____
_____

Recommendation(s) / Referral(s) _____
_____

SIGNATURE SECTION – Required for ALL students

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 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

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FOUNDED IN 1877

Bryn Athyn College Health Services

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