

BRYN ATHYN COLLEGE

Medical Form

The medical form must be submitted by June 30.

A student may not move into campus housing nor take part in any campus activity (i.e. athletics, orientation, registration or social events) until the student's medical form has been reviewed and cleared by clinic staff.

Vaccinations

Bryn Athyn College requires all students to comply with the vaccination schedule indicated in the "Physician Section" of this form. Please read the section carefully.

Any student found to be out of compliance with the vaccine schedule will be expected to obtain missing vaccinations at his or her own expense.

Purchasing vaccines out of pocket is very costly. Students should make every effort to comply with requirements before arrival on campus. If a student is unable to obtain a vaccine in his or her country of origin, the student will be required to obtain missing vaccines prior to moving into campus housing. In this case, the student must be prepared to reside off-campus until fully cleared.

Students may request an exemption from vaccine requirements by providing a physician's statement indicating the reason for exemption, or by providing a personal written statement of religious objection to vaccination. Exemption requests must be filed with the medical form prior to registration for courses.

Health Services

Bryn Athyn College maintains a health clinic with a physician and registered nurses to see students during scheduled hours. In addition, a nurse is on call during nights and weekends. Students are free to consult other physicians but must do so at their own expense.

Although routine care is provided for resident students, there are times when emergency treatment or tests are necessary outside the scope of our campus health services.

All full-time students must carry medical insurance coverage while at Bryn Athyn College. All medical expenses not covered by insurance are the student's responsibility.

Insurance

To avoid unnecessary expense, carefully complete the insurance section included with this form. **Students who do not show proof of insurance by June 30 will automatically be enrolled in the college's plan and will be responsible for the amount billed to their account.**

Completed Forms

The completed forms should be returned to the Bryn Athyn College Admissions Office by June 30.

Bryn Athyn College Admissions Office
PO Box 462
Bryn Athyn, PA 19009 USA

Please contact the Doering Health Clinic with any questions:

Email: allyn.simons@anc-gc.org, crystal.zecher@anc-gc.org
Phone: (267) 502-4582

Medical Form Checklist:

Before you submit your form, check off the following:

- Are your vaccines complete?**
- Did your physician sign your form?**
- Did you complete the insurance form?**
- Are all pages fully completed?**

Student Section *This portion must be filled out completely, and should be completed by the student.*

General Information

Legal Name: _____ Male: _____ Female: _____
LAST FIRST MIDDLE

Home Address: _____
STREET/P.O. BOX APT. NO.

Phone: (____) _____
HOME CELL CITY STATE/PROVINCE ZIP/POSTAL CODE COUNTRY

Email Address: _____

Birth Date: ____/____/____ Social Security Number (if any): _____
MONTH DAY YEAR

Expected length of enrollment: Full year Partial year Fall Winter Spring

Person to notify in case of emergency: _____

Phone: (____) _____ Relationship to Student: _____

Insurance Data

Please select the one statement that applies to you and provide all requested information in that section:

I am a US citizen or permanent resident. I have health insurance. I have enclosed a copy of my insurance card (both front and back).

Policy Holder's Name: _____ Birth Date: ____/____/____
MONTH DAY YEAR

Name of Insurance Carrier: _____ Group No.: _____ I.D. No.: _____

Insurance Company Address: _____
STREET/P.O. BOX APT. NO.

Phone: (____) _____
CITY STATE/PROVINCE ZIP/POSTAL CODE COUNTRY

I am a US citizen or permanent resident. I do not have health insurance. Please enroll me in the college-sponsored plan.

I am an international student — please enroll me in the college-sponsored insurance plan.

International students must be enrolled in the college-sponsored plan. The cost is automatically charged to your account and is non-refundable. No substitute policies accepted.

Citizen of what country? _____

History

Have you had any of the following conditions? *Give details below, including dates.*

	YES	NO	EXPLAIN "YES" ANSWERS	DATE
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Allergy to any medicine	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Asthma or respiratory	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Past surgeries/injuries	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Wear glasses/contacts	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Anything not listed	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

You must answer completely by giving approximate date if you had this illness. If unknown, write "unknown."

Measles: _____ Mumps: _____ Rubella (German measles): _____ Varicella (chicken pox): _____ Polio: _____

Tuberculosis (TB) Screening Questionnaire

Student Name: _____

Date: _____

Bryn Athyn College asks that you answer the following questions in order to screen for Tuberculosis (TB). You will be contacted if further assessment is needed.

	YES	NO
Have you ever had a positive TB skin test?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had close contact with anyone who was sick with TB?	<input type="checkbox"/>	<input type="checkbox"/>
Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? *(If yes, please CIRCLE the country)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever traveled**to/in or will you be traveling to one or more of the countries listed below? (If yes, please CHECK the country/countries)	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been vaccinated with BCG?	<input type="checkbox"/>	<input type="checkbox"/>

*Future CDC updates may eliminate the 5 year time frame

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

Afghanistan	Croatia	Lao PDR	Papua New Guinea	Tunisia
Algeria	Djibouti	Latvia	Paraguay	Turkey
Angola	Dominican Rep.	Lesotho	Peru	Turkmenistan
Anguilla	Ecuador	Liberia	Phillippines	Tuvalu
Argentina	Egypt	Lithuania	Poland	Uganda
Armenia	El Salvador	Macedonia	Portugal	Ukraine
Azerbaijan	Equatorial Guinea	TFYR	Qatar	United Arab
Bahamas	Eritrea	Madagascar	Romania	Emirates
Bahrain	Estonia	Malawi	Russian Federation	United Kingdom
Bangladesh	Etiopía	Malaysia	Rwanda	Uruguay
Belarus	Fiji	Maldives	St Vincent &	Uzbekistan
Belice	French Polynesia	Mali	The Grenadines	Vanuatu
Benin	Gabon	Marshall Islands	Sao Tome &	Venezuela
Bhutan	Gambia	Mauritania	Principe	Viet Nam
Bolivia	Georgia	Mauritius	Saudi Arabia	Wallis & Futura Islands
Bosnia &	Ghana	Mexico	Senegal	W. Bank & Gaza Strip
Herzegovina	Guam	Micronesia	Seychelles	Yemen
Botswana	Guatemala	Moldova-Rep.	Sierra Leone	Zambia
Brazil	Guinea	Mongolia	Singapore	Zimbabwe
Brunei	Guinea-Bissau	Montenegro	Solomon Islands	
Darussalam	Guyana	Morocco	Somalia	
Bulgaria	Haiti	Mozambique	South Africa	
Burkina Faso	Honduras	Myanmar	Spain	
Burundi	India	Namibia	Sri Lanka	
Cambodia	Indonesia	Nauru	Sudan	
Cameroon	Iran	Nepal	Suriname	
Cape Verde	Iraq	New Caledonia	Syrian Arab Rep.	
Central Africa Rep.	Japan	Nicaragua	Swaziland	
Chad	Kazakhstan	Niger	Tajikistan	
China	Kenya	Nigeria	Tanzania-UR	
Colombia	Kiribati	Niue	Thailand	
Comoros	Korea DPR	N. Mariana Islands	Timor-Leste	
Congo	Korea-Republic	Pakistan	Togo	
Congo DR	Kuwait	Palau	Tokelau	
Cote d'Ivoire	Kyrgyzstan	Panama	Tonga	

Continue

Physician Section *This section must be completed and signed by the examining physician or family nurse practitioner.*

Student's Name: _____ Male Female Age: _____

MEDICAL	NORMAL	ABNORMAL	EXPLAIN FINDINGS
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiopulmonary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	_____
EENT	<input type="checkbox"/>	<input type="checkbox"/>	_____
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Metabolism	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Vaccines

The following vaccines are REQUIRED for attendance. **An incomplete vaccination record will prevent registration.**
Any waiver request for medical or religious reasons must be on file prior to the start of classes.

VACCINE	DOSES (ENTER MONTH, DAY, AND YEAR EACH IMMUNIZATION WAS GIVEN)				
Diphtheria and Tetanus*	1 _____	2 _____	3 _____	4 _____	5 _____
Tdap Booster (within 5 yrs)	1 _____				
Polio**	1 _____	2 _____	3 _____	4** _____	5 _____
Measles (2) (Hard, Red)	1 _____	2 _____			
or Measles Serology			Titer: _____	Date: _____	
Rubella (German Measles)	1 _____				
or Rubella Serology			Titer: _____	Date: _____	
Mumps (2)	1 _____	2 _____			
or Mumps disease diagnosed by a physician			Date: _____		
Hepatitis B (3)	1 _____	2 _____	3 _____		
Varicella (disease, titer, or dates of 2 doses)	1 _____	2 _____	Disease: _____	Titer: _____	

* Tetanus and Diphtheria are usually received in combined vaccines such as DTP, DT or TD. Three doses required, and Tdap booster.

** Polio—3 doses of Oral or 4 doses of Inactivated (Salk) vaccine are required.

Meningitis Vaccine (required for all resident students) Date: _____ **Other** (specify): _____

Tuberculin Test Date Applied: _____ Arm: _____ Device: _____ Antigen: _____
Manufacturer: _____ Signature: _____
Date Read: _____ Results (mm): _____

Vital Signs: _____ **Height:** _____ **Weight:** _____

Physician Summary and Recommendations

- Cleared for sports
- Cleared for sports with the following restrictions: _____
- Not cleared for sports. Reason(s): _____
- Any other recommendations for this student? _____

Physician Information and Signature

PHYSICIAN'S SIGNATURE

DATE OF EXAM

PHYSICIAN'S PRINTED NAME

TELEPHONE

Physician's Address: _____
STREET/P.O. BOX

CITY

STATE/PROVINCE

ZIP