Once the Health Information Packet has been reviewed and completed, it can be submitted to Admissions, mailed to the Student Health Center, or submitted by fax 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.

Packet Checklist

- Student Information Page
- Health History Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health History Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Hippa/Ferpa/Insurance Form
- Copy of Insurance Card
- Immunization Record Form (to be reviewed and signed by physician)
- COVID-19 Vaccination Card (required for residential living)
- Health Services TB Questionnaire Part 1 (to be filled out by student and reviewed by physician)
- Health Services TB Questionnaire Part 2 (to be filled out by student and reviewed by physician)
- Physical Form Part 1 (to be completed by physician)
- Physical Form Part 2 (to be completed and signed by physician)

Instructions

- Keep a COPY of this form, and any attachments for your records
- Submission of this form is MANDATORY for all BAC students
- Athletes: to participate in a sport at BAC a COMPLETED medical form MUST BE SUBMITTED to Bryn Athyn Health Services PRIOR to ANY NCAA tryout/participation.

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: 267-502-6077 | Fax: 267-502-6024
Name: ____________________________________________ (LAST) (FIRST) (MIDDLE) Start Term: ____________ Date of Birth: ____________ (MONTH/YEAR) (MONTH/DAY/YEAR)

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

Emergency Contact

NAME: ____________________________________________ RELATIONSHIP: ____________________________________________
ADDRESS: ____________________________________________
CITY: ____________________________________________
STATE: ____________________________________________ ZIP: ____________________________________________ COUNTRY: ____________________________________________
HOME PHONE NUMBER: ____________________________________________
WORK PHONE NUMBER: ____________________________________________
CELL PHONE NUMBER: ____________________________________________

FAILURE TO COMPLETE THIS HEALTH FORM RESULTS IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING.
Part 1

Name: ___________________________  Start Term: ____________  Date of Birth: _____________

(LAST)  (FIRST)  (MIDDLE)  (MONTH/YEAR)  (MONTH/DAY/YEAR)

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

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Times Taken Per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

ALLERGIES/REACTIONS

<table>
<thead>
<tr>
<th>Medicine/Food/Agent</th>
<th>Reactions/ Side Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

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

B. CARDIOVASCULAR
- Fainting
- Blood Disorder
- Heart Condition (list): ______________________

- Blood Pressure Abnormalities
- Heart Murmur
- Chest Pain/ Discomfort

C. GASTROINTESTINAL
- Chronic Inflammatory Bowel Disease
- Digestive Problems (describe): ______________________

- Acid Reflux
- Hernia
- Gallbladder Disease
- Liver Disease

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

E. INFECTIOUS DISEASES
- Chicken Pox
- Viral Hepatitis
- Infectious Mononucleosis (Mono)
- MRSA (Methicillin Resistant Staph Aureus)

- Positive TB Testing
- Preventative INH Treatment for Tuberculosis
  - Date: ______________________
  - Length of Treatment: ______________________

- HIV

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

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

H. MEN’S HEALTH
- Testicular Problems

I. WOMEN’S HEALTH
- Irregular Menses
- Painful Menses
- Last menstrual period ______________________

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

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

K. ILLNESSES NOT LISTED ABOVE: ____________________________
   ____________________________
   ____________________________
   ____________________________

L. SURGERIES AND HOSPITALIZATIONS
Dates: Specify reason:
   ____________________________
   ____________________________
   ____________________________

M. ORTHOPEDIC HISTORY - Have You Ever Had an Injury to:
   ☐ Shoulder (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Elbow/Wrist/Arm/Hand (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Lower Leg (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Knee (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Ankle/Foot (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Hip/Groin (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________
   
   ☐ Back/Ribs (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________

   ☐ Neck (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________

   ☐ Physical Disability (describe): ____________________________
   ____________________________
   ____________________________
   ____________________________

N. FAMILY HISTORY
Have any of your blood relatives had any of the following?
High Blood Pressure
   ☐ yes ☐ no

Heart Disease (heart murmur, hypertrophy, irregular heart beat, Marfan’s Syndrome, heart attack, stroke)
   ☐ yes ☐ no

Diabetes
   ☐ yes ☐ no

Non-accidental/sudden death in immediate family before age 50
   ☐ yes ☐ no

Please explain any YES responses below:
   ________________
   ____________________________
   ____________________________

O. CONCUSSION HISTORY
Have you ever been diagnosed with a concussion?
   ☐ yes ☐ no ☐ 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”
   ☐ yes ☐ no

   Did you have to go to the hospital?
   ☐ yes ☐ no
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: ________________
## Immunization Record Form

### Vaccines

<table>
<thead>
<tr>
<th>Vaccines</th>
<th>Dates Given/Performed</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong></td>
<td></td>
<td>• 2 doses of MMR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Minimum of 4 weeks between doses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First dose given after 1st birthday</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Second dose after age 4</td>
</tr>
<tr>
<td><strong>Individual Vaccines:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>Dose 1 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 2 doses of each individual component (2 measles, 2 mumps, 2 rubella)</td>
</tr>
<tr>
<td></td>
<td>Dose 2 _____ / _____ / _____</td>
<td>• Minimum of 4 weeks between doses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• First dose given after 1st birthday</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The second dose is recommended after age 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>Dose 1 _____ / _____ / _____</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>Dose 1 _____ / _____ / _____</td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>Dose 2 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td>Positive blood test showing immunity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles titer date</td>
<td>MM/DD/YYYY</td>
<td>Result ______________________</td>
</tr>
<tr>
<td>Mumps titer date</td>
<td>MM/DD/YYYY</td>
<td>Result ______________________</td>
</tr>
<tr>
<td>Rubella titer date</td>
<td>MM/DD/YYYY</td>
<td>Result ______________________</td>
</tr>
<tr>
<td><strong>Meningococcal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(meningitis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group A</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If initial dose is given under 16 years of age, two doses are required.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If initial dose is given at 16 years of age or older, one dose is required.</td>
</tr>
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<tr>
<td></td>
<td></td>
<td>Check One</td>
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<tr>
<td></td>
<td></td>
<td>o Menactra</td>
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<tr>
<td></td>
<td></td>
<td>o Menveo</td>
</tr>
<tr>
<td><strong>Meningococcal</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(required for residential living)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Group B</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• required for residential living</td>
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<tr>
<td></td>
<td></td>
<td>• 2 doses at least one month apart (for Bexsero)</td>
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<tr>
<td></td>
<td></td>
<td>• 3 doses at 0, 2 and 6 months (for Trumenba)</td>
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<tr>
<td>Varicella (chicken pox)</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Dose 1 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose 2 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR MM/DD/YYYY</td>
<td></td>
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<tr>
<td>Tdap within 10 years</td>
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<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Hepatitis B or Twinrix</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(optional, but recommended)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose 1 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose 2 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dose 3 _____ / _____ / _____</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR MM/DD/YYYY</td>
<td></td>
</tr>
</tbody>
</table>

### Practitioners Signature Required

*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.*
### Health Services TB Questionnaire Part 1

**Name:** ____________________________________________  **Start Term:** ____________  **Date of Birth:** _____________

**REQUIRED! THIS SECTION MUST BE COMPLETED BY ALL STUDENTS, NOT YOUR DOCTOR.**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever had close contact with persons with known or active TB (tuberculosis) disease?</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
<tr>
<td>3. If yes, what country? (circle the country/countries in the list below)</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
<tr>
<td>5. If yes, where?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease?</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td>[ ] Yes  [ ] No</td>
<td></td>
</tr>
</tbody>
</table>

**Countries listed with high incidence of active TB:**

- 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, 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
- N - Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue
- P - Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal
- Q - Qatar
- R - Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda
- 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
Does the student have signs or symptoms of active pulmonary tuberculosis disease?  □ Yes  □ No
If yes, check below and proceed:
□ Cough (especially if lasting for 3 weeks or longer)  □ Coughing up blood (hemoptysis)
□ Chest pain with or without sputum production  □ Loss of appetite
□ Unexplained weight loss  □ Night sweats
□ Fever

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)
(TMST result should be recorded as actual millimeters (mm) of induration, 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.

Interferon-based Assay TB Blood Test
Quantiferon Gold Test or T-Spot
*Must be performed in the United States.

Date of blood test

Date of X-ray

Attach X-Ray report in English

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

Treatment for latent TB (check one)
□ Patient completed full course of treatment for latent TB.
Medication and dates ____________________________________________________________

□ Patient did not complete treatment for latent TB.
Reason ____________________________________________________________
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?  
☐ yes  ☐ no

Please explain:______________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

Is the student under treatment for Eating Disorder, Behavioral, OR Psychiatric Problems?  
☐ yes  ☐ no

Please explain:______________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

Does the student have Physical Disabilities OR Assisted Devices?  
☐ yes  ☐ no

Please explain:______________________________________________________________________________________________________________
__________________________________________________________________________________________________________________________

CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>MEDICAL:</th>
<th>NORMAL</th>
<th>ABNORMAL (PLEASE EXPLAIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>BP ☑ T ☑ P ☑ R ☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height ☑ Weight ☑</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, Face, Neck, and Scalp</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visual acuity and ophthalmic exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears/Nose/Throat/Sinuses/Mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs and Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
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<tr>
<td>Neurological</td>
<td></td>
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<tr>
<td>G-U</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menstrual History</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
### NCAA SPORTS/COLLEGE INTRAMURAL CLEARANCES

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

#### Q CLEARED

#### Q CLEARED, with recommendation(s) for further evaluation or treatment for:

<table>
<thead>
<tr>
<th>Recommendation(s) / Referral(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

#### Q NOT CLEARED for the following types of sports/intramurals (please check those that apply:)

- [ ] Contact
- [ ] Non-Contact
- [ ] Strenuous Activities

Due to

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<th>Reason(s)</th>
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Recommendation(s) / Referral(s)

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### SIGNATURE SECTION

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 NCAA sports/college intramural activities.

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<tr>
<th>Signature of Health Care Provider</th>
<th>License Number</th>
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<th>Print Name of Health Care Provider</th>
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