

Dickinson College Student Health Services



Accredited by
Accreditation Association for Ambulatory Health Care, Inc.

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Instructions for Completing Medical / Health Forms

Pre-Admission Immunization Policy

Carefully review the College's Pre-admission Immunization Requirements document, print, and take to your health care provider for their reference while completing your Physical Exam and Immunization forms.

- **Please note any deficiencies in required immunizations may cause a delay in getting your room key on opening day.**

Health History Form

The Medical / Health History form must be completed by the student on-line through their Gateway account. To do so, please go to Dickinson Gateway by directing your Web browser to <http://gateway.dickinson.edu/>. Your Gateway user name and password were sent to you from the Orientation Office with the Orientation Brochure. Once you are in the Gateway, select the Student Forms tab and click on the Medical/Health History form to complete the on-line form. The meningitis waiver is also on-line and must be completed if you have not had a meningitis vaccine.

- If for some reason you are unable to complete and submit the on-line Medical/Health History form, you may download the form located on the Student Health Services webpage at: http://dickinson.edu/uploadedFiles/student_life/resources/health_center/content/HX-Pg1-10-11.pdf
- Complete the paper Medical / Health History form **only if you cannot complete it on-line**, and mail it along with your Immunization and Physical Exam form which your health care provider must complete.
- **Please do not send a hard copy of the Medical / Health History form if you have submitted the information on-line.**

Immunizations, Physical Exam, and TB Screening Forms can be found on pages 3, 4 and 5 of this document. These sections must be completed by your health care provider.

If you are at risk for TB (as determined by the on-line Gateway TB risk assessment questionnaire), see page 5 of this form, which your physician must complete.

DICKINSON COLLEGE STUDENT HEALTH SERVICES & PENNSYLVANIA PRE-ADMISSION IMMUNIZATION REQUIREMENTS

MMR- MEASLES (Rubeola) , MUMPS, GERMAN MEASLES (Rubella)

Physician documentation of immunization with **two** live virus vaccine on or after 12 -15 months of age and second dose at age 4-6 years or later or positive serologic test demonstrating immunity to all three diseases. Neither a personal nor a physician certified history of Rubella is acceptable evidence of immunity.

Contraindications to rubella vaccine: pregnancy, history of hypersensitivity or anaphylaxis to any of the components in the vaccine, neomycin allergy, and altered immune status.

TETANUS, DIPHTHERIA, PERTUSSIS (DT, DTaP / DTP, Td, or Tdap)

A tetanus and diphtheria Td or Tdap booster is required within 10 years of admission if the student has a documented history of receiving a primary series of DT, DTaP DTP, or Td, or Tdap.

If never immunized against tetanus, diphtheria or pertussis: follow CDC guidelines.

POLIOMYELITIS

Primary immunization should be completed with oral polio vaccine (OPV) or inactivated polio vaccine (IPV) prior to the first birthday. Consult your physician for vaccination procedure, if needed.

Contraindications: pregnancy, altered immune status.

HEPATITIS B

Immunization consists of a three dose series. The series must be started prior to entry and completed during the first six months at Dickinson. Hepatitis B vaccine is available at the Health Center.

MENINGITIS

Pennsylvania State law requires all college students be given information about meningitis disease and information about the vaccine. Colleges and Universities are required to obtain proof of vaccine or have a signed waiver from the student prior to providing housing.

VARICELLA (Chicken pox)

Parental or physician certified history of illness, positive serologic test demonstrating immunity, or physician documentation of two doses of vaccine at least 12 weeks apart if given prior to age 13 or 4 weeks apart if given on or after the 13th birthday.

Contraindications to vaccine: allergic reaction to neomycin, pregnant or nursing females, and altered immune status.

TUBERCULOSIS SCREENING TEST

A test for tuberculosis (PPD – Mantoux) is required on all students who meet the “high risk” criteria, regardless of previous BCG inoculation. If PPD positive, a chest x-ray is required.

The following are recommended but not required.

HPV – Human Papillomavirus Vaccine

Recommended for all entering females students. Please discuss with your health care provider.

HEPATITIS A VACCINE

Recommended and given as a series of 2 doses with the second dose given 6-12 months after the first. Please discuss with your healthcare provider.

PNEUMOCOCCAL VACCINE

Recommended for young adults with certain medical conditions: chronic pulmonary disease (including asthma and current history of smoking for college students 19-64 years old), chronic cardiovascular disease, diabetes, chronic liver disease, functional or anatomical asplenia, and immunosuppressive conditions. Please discuss with your health care provider.

Last Name _____ First Name _____ MI _____ DOB _____

Physical Exam – to be completed by Health Care provider

Male Female Age _____ Height _____ Weight _____ BP ____/____ Pulse _____

Enter "N.E." if not evaluated. WNL ABN. Give detail of abnormality

Head, Neck, Face, and Scalp			
Nose and Sinuses			
Mouth, Teeth, Gingiva, and Throat			
Ears			
Eyes			
Lungs, Chest, and Breasts			
Heart			
Abdomen			
Thyroid			
Genito-Urinary System			
Musculoskeletal			
Skin and Lymphatic (include acne)			
Neurological system			
Psychiatric			
Is this individual capable of normal physical activity? (athletics, physical education) <input type="checkbox"/> Yes <input type="checkbox"/> No			
If not, give reasons and limitations on comments line below.			

Past Medical History	Yes	No		Yes	No
Physical disability			Learning disorder		
Emotional/psychiatric disability			Eating disorder (anorexia/bulimia)		

The student has no disabilities

Comments or other **pertinent past medical history:**

PLEASE COMPLETE THE REQUIRED TB SCREENING TOOL ON THE REVERSE SIDE.

I certify I have reviewed the health history, immunization information and completed the TB screening on the reverse side of this form, and I have performed a physical exam on the above named patient and find him/her to be physically and emotionally healthy to the extent of participating in activities related to normal college life.

Date of Examination _____

Please print, stamp or type name and phone number _____

Address _____

City _____ State _____ Zip Code _____

DICKINSON COLLEGE STUDENT HEALTH SERVICES

TB Risk Assessment

Persons with any of the following risk factors are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Recent close contact with someone with infectious TB disease Yes No

Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America) Yes No

Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease Yes No

HIV/AIDS Yes No History of illicit drug use Yes No

Organ transplant recipient Yes No

Immunosuppressed (equivalent of >15mg/day of prednisone for >1 month or TNF- α antagonist) Yes 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) Yes 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)] Yes 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 patient has no risk factors, and has no signs of TB, nothing further needs to be done.

If the patient has risk factor or has signs or symptoms of active TB, proceed to 2 or 3 below and additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

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

The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ___/___/___
 M D Y

Date Read: ___/___/___
 M D Y

Result: _____ mm of induration

**Interpretation: positive negative

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ___/___/___ (specify method) QFT-G QFT-GIT other_____
 M D Y

Result: negative____ positive____ intermediate____

Date Obtained: ___/___/___ (specify method) QFT-G QFT-GIT other_____
 M D Y

Result: negative____ positive____ intermediate____

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

Date of chest x-ray: ___/___/___
 M D Y

Result: normal abnormal

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

➤ 5mm	➤ 10 mm	➤ 15 mm
Recent close contacts of an individual with infectious TB • Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease • Organ transplant recipients • Immunosuppressed persons: taking >15mg/d of prednisone for >1 month; taking a TNF- α antagonist • Persons with HIV/AIDS	• Persons born in a high prevalence country or who resided in one for a significant* amount of time • History of illicit drug use • Mycobacteriology laboratory personnel • History of resident, worker, or volunteer in high-risk congregate settings • Persons with the following clinical conditions: diabetes mellitus, silicosis, chronic renal failure, leukemias and lymphomas, head, neck, or lung cancer, intestinal bypass or gastrectomy, chronic malabsorption syndromes, low body weight (> 10% below ideal)	• Persons with no known risk factors for TB disease

HEALTH CARE PROVIDER

Name _____

Address _____

Signature _____

Phone () _____