

Dickinson College Student Health Services



Accredited by

Accreditation Association for Ambulatory Health Care, Inc.

P.O. Box 1773
Carlisle, PA 17013

<http://www.dickinson.edu/student-life/resources/health-center/>

717-245-1835 (TEL)

717-245-1938 (FAX)

E-mail: health@dickinson.edu

Dear Student:

On behalf of the Dickinson College Student Health Services, we would like to extend to you a very warm welcome! In order for us to provide you the best possible care, the College **requires** that you complete the medical/health history form online and submit the health care provider's completed health forms to our office by Fri. July 8, 2011.

You are required to have a physical exam, so please call to make an appointment with your health care provider as soon as possible.

Online Medical/Health History Form: The form must be completed online through Dickinson Gateway. Your Gateway user name and password were included in your Orientation brochure. To complete online, the web address is <http://gateway.dickinson.edu>. If you are unable to complete the form online, you may download the form from our web page <http://www.dickinson.edu/student-life/resources/health-center/content/Health-Forms-and-Policies/>.

Complete and submit the hardcopy ONLY if you cannot complete it online.

Medical Record Form: The form must be completed and signed by your health care provider. Please note that the College has a Pre-Admission Immunization Policy stating that all students must provide to our office documentation of required vaccinations and/or immune status by laboratory confirmation.

Meningitis: The State of Pennsylvania requires all students to have a current meningitis vaccine or sign a waiver declining it before being housed on campus. If the waiver option is chosen, it can be completed as part of the online health history form or downloaded and printed from our web page <http://www.dickinson.edu/student-life/resources/health-center/content/meningitis>.

Allergy Injections or Chronic Medical Conditions: If you are under medical care for an ongoing or chronic medical condition, a summary from your health care provider should be sent to the Director of Student Health Services. Allergy injections may be continued while here, however, additional forms are required from your health care provider. You can find them on our web page <http://www.dickinson.edu/student-life/resources/health-center/content/Health-Forms-and-Policies/>.

Health Insurance: All students are **required to have health insurance** and are eligible to be seen at the Health Center at no cost for the visit, regardless of health insurance. There may be nominal fees for associated services; however, presently we do not bill insurance companies. If any charges apply, a receipt is provided at the time of visit that can be submitted to insurance for reimbursement. You may waive out of the College-sponsored health insurance if coverage is comparable and, in effect while here at Dickinson. For more information concerning the College's policy regarding mandatory health insurance, please go to <http://www.dickinson.edu/about/offices/financial-operations/content/student-accounts/Health-Insurance/>.

If you have any questions concerning health services or policies, please e-mail health@dickinson.edu or visit our web page <http://www.dickinson.edu/student-life/resources/health-center/>. We look forward to helping you make your time at Dickinson a healthy and happy experience.

Sincerely,

Mary Polson, MSN, CRNP
Director, Student Health Services



DICKINSON COLLEGE PRE-ADMISSION IMMUNIZATION POLICY

Dickinson College Pre-Admission Immunization Policy has been established in accordance with recommendations on vaccine-preventable diseases from the CDC.

VACCINE	VACCINATION SCHEDULE	DOCUMENTATION REQUIRED
Measles, Mumps, Rubella (MMR)	Two doses of MMR at least 28 days apart after 12 months of age.	Provider-verified documentation of vaccine dates <i>or</i> positive serologic test demonstrating immunity.
Tetanus, Diphtheria, Pertussis (TDAP)	One dose of Tdap regardless of interval since last Td booster.	Provider-verified documentation of vaccine date.
Polio	Primary series should be completed with IPV or OPV.	Provider-verified documentation of vaccine dates.
Varicella	Two doses of varicella vaccine at least 12 weeks apart if vaccinated between 1 and 12 years of age and at least 4 weeks apart if vaccinated at age 13 years or older.	Provider-verified documentation <i>or</i> history of disease <i>or</i> positive serologic test demonstrating immunity.
Hepatitis B	Series of three age appropriate doses (given at 0, 1-2 mo., and 6-12 mo) at any age. Alternatively, 2 adult doses (given at 0, and 4-6 mo.) if vaccinated between 11-15 years of age.	Provider-verified documentation of vaccine dates <i>or</i> positive serologic test demonstrating immunity.
Meningococcal Quadrivalent	Initial dose of conjugate vaccine: 11-12 years of age. Booster dose: If initial dose < 16 years; booster dose at 16-18 years of age. If initial dose given age ≥ 16 years, no booster is needed.	Provider-verified documentation of vaccines <i>or</i> signed waiver*.
<p>*The State of Pennsylvania requires all students to provide proof of immunization or sign a waiver declining the meningitis vaccine in order to be housed on campus.</p>		
Tuberculosis Screening Test	A tuberculin skin test (TST) <i>or</i> Interferon Gamma Release Assay (IGRA) blood test is required on all students who meet the "high risk" criteria, <u>regardless of previous BCG inoculation.</u> Positive Results: if positive, a chest x-ray is required.	Provider-verified documentation of TST <i>or</i> IGRA results.
<p>The following vaccines are strongly recommended, but not required:</p>		
HPV	Series of three vaccines.	
FLU VACCINE	Given on an annual basis.	

Dickinson College has a Pre-Admission Immunization Policy to protect the health and well being of the entire campus community. Students who have not completed the immunization requirements will not be able to directly check into their housing assignment upon arrival to campus.

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Health Forms Checklist

We have provided the following checklist in order to help you meet the mandatory health-related requirements:

Physical Exam

- Call your health care provider to schedule physical exam appointment

Welcome Letter and Pre-Admission Immunization Policy

- Carefully review the Welcome letter and Pre-admission Immunization Policy
- Take Pre-Admission Immunization Policy with you to your physical exam appointment for your health care provider's reference

Online Medical/Health History Form (in Gateway)

Complete all sections of the form:

- Medical/Health history
- Meningitis vaccine information or waiver
- TB Risk Assessment
- Social History
- Acknowledgement Statement

Medical Record Form

Have your health care provider complete all pages :

- Immunization Record – page 1
- Physical Exam – page 2
- Tuberculosis TB Screening – page 3

Health Insurance Waiver or Enrollment

- Go to Student Accounts web page <http://www.dickinson.edu/about/offices/financial-operations/content/student-accounts/Health-Insurance/> to complete online

Last Name _____ First Name _____ MI _____ DOB _____

IMMUNIZATION RECORD

To be completed and signed by health care provider. (All information must be provided in English)

REQUIRED IMMUNIZATIONS

Dates of Immunizations or titers (copy of lab results required)

MMR	Dose 1	Given on or after 1 st birthday	
	Dose 2	Given 1 month after Dose 1	

OR

MEASLES (RUBEOLA)	Dose 1	Given on or after 1 st birthday	
	Dose 2	Given 1 month after Dose 1	

OR

Serological Immunity/titer Immune Not Immune

MUMPS	Dose 1	Given on or after 1 st birthday	
	Dose 2	Given month after Dose 1	

OR

Serological Immunity titer Immune Not Immune

RUBELLA (GERMAN MEASLES)	Dose 1	Given on or after 1 st birthday	
	Dose 2	Given 1 month after Dose 1	

OR

Serological Immunity/titer Immune Not Immune

HEPATITIS B	Dose 1		
	Dose 2	Given 1 month after 1 st dose	
	Dose 3	Given 6 months after 1 st dose	

OR

Serological Immunity/titer Immune Not Immune

TDAP	Initial Dose	
	Booster	

POLIO	Date Completed Series or Booster	
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VARICELLA (Chicken pox)	Dose 1		
	Dose 2	Given 4-8 weeks after 1st dose	
	History of Illness (age)		

OR

Serological Immunity titer Immune Not Immune

TUBERCULOSIS SCREENING	<input type="checkbox"/> Not High Risk
	<input type="checkbox"/> High Risk (TST required)

MENINGITIS <input type="checkbox"/> MCV4 <input type="checkbox"/> MPSV4	Initial Dose	
	Booster	

OR

Waiver Signed

RECOMMENDED IMMUNIZATIONS

HUMAN PAPILLOMAVIRUS VACCINE (HPV)	Dose 1	
	Dose 2	Given 2 months after 1st dose
	Dose 3	Given 6 months after 1 st dose

For office use only:			
<input type="checkbox"/> Form Complete	<input type="checkbox"/> Form Incomplete	<input type="checkbox"/> Resolved (date) _____	
Missing _____			
<input type="checkbox"/> Written/Verbal Notification (date) _____	<input type="checkbox"/> Entered _____		

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) Yes 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 PRIOR TO SIGNING FORM

I certify that I have reviewed the health history, immunization information, and completed the TB screening.

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

Health Care Provider signature

Last Name _____ First Name _____ MI _____ DOB _____

TUBERCULOSIS (TB) SCREENING

Tuberculosis screening is required on all students entering Dickinson College, based upon guidelines of the American College Health Association and the U.S. Centers for Disease Control.

To Be Completed by Health Care Provider Only

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

- ◀ Unexplained elevation of temperature for more than one week, weight loss, night sweats,
persistent cough for more than three weeks
◀ Cough with production of bloody sputum (hemoptysis)

Has the student ever had a positive Tuberculin Skin Test (TST) or QUANTI-FERON TB Test? Yes No

Is the student a member of a high-risk group? Yes No

- ◀ Had close contact with a known case of active tuberculosis
◀ Use of illegal injected drugs
◀ Currently on immunosuppressive therapy
◀ Resident, employee, or volunteer in a nursing home, homeless shelter, correctional facility,
or other health care facility

Has the student lived or traveled in countries where TB is endemic? Yes No

- ◀ Includes students who have arrived in the US in the past five years from countries **OTHER THAN**
Albania, American Samoa, Andorra, Antigua and Barbuda, Australia, Austria, Barbados, Belgium, Bermuda,
British Virgin Islands, Canada, Cayman Islands, Chile, Cook Island, Costa Rica, Cyprus, Czech Republic, Denmark,
Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan,
Lebanon, Libyan Arab Jamahiya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles,
New Zealand, Norway, Puerto Rico, Saint Kitts and Nevis, St. Lucia, Samoa, San Marino, Slovakia, Slovenia,
Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom,
United States Virgin Islands, United States.

If all above answers are no, please indicate "Not HR" on Immunization Record. If answered yes to any of the above questions, Dickinson College requires that the student undergo tuberculosis screening documented below:

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

If No, proceed to #2. If yes, proceed with additional evaluation to exclude active tuberculosis disease, including screening test, chest x-ray, and sputum evaluation as indicated.

2. **A screening test for tuberculosis is required. Indicate test performed below.**

If positive, proceed to #3.

Quanti-FERON Blood test

Date Obtained: _____

Result: Negative Positive Indeterminate

OR

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: _____ Result: _____ mm of induration

3. **Chest X-ray:** Copy of chest x-ray report is required.

Date Obtained: _____ Result: Normal Abnormal

Treatment with INH

Date Started: _____ Date Completed: _____ Declined