AGNES SCOTT
COLLEGE

Medical Examination Form

Students may use this form or one provided by their healthcare provider

Last Name _____ First Name _____ MI _____

Date of Birth ____/____/____ Student ID# _____ Date of most recent exam*: _____

***Must be within the past 12 months.**

To the provider: please review personal and family health history and complete this form. Please note that a **signature from the provider is required.**

BP: _____ HR: _____ Height: _____ Weight: _____

	Normal	Abnormal	Comments:
Skin:	☐	☐	_____
HEENT:	☐	☐	_____
Cardiac:	☐	☐	_____
Pulmonary:	☐	☐	_____
Abdominal/GI:	☐	☐	_____
Musculoskeletal:	☐	☐	_____
Neurological:	☐	☐	_____

Does the student have any allergy to foods or drugs? If so, please list. _____

_____

Please list hospitalizations/surgery dates: _____

_____

May the student participate in competitive athletic programs? (circle one) Yes / No

Is this student under any form of medical treatment and/or prescription medication? If so, please list. _____

_____

Has the student ever had an eating disorder? If yes, please explain: _____

_____

Are there any special accommodations needed? If so, please explain: _____

_____

HEALTH CARE PROVIDER (MD/DO/NP/PA)

Name _____ Signature _____ Date _____

Address _____

Phone (_____)_____

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Immunization Form

PART I

Last Name _____First Name _____ MI_____

Date of Birth _____ Student ID# _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER

All information must be in English. Record complete dates: MM/DD/YYYY of vaccination doses administered.

REQUIRED VACCINATIONS

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later #1 ____/____/_____
2. Dose 2 given at least 28 days after first dose. #2 ____/____/_____

OR provide lab tests indicating immunity to measles, mumps, and/or rubella (attach lab reports)

B. HEPATITIS B

Either 3 dose series or 2 dose series or QUANTITATIVE Hepatitis B lab report attached

1. Immunization: Heplisav-B
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3____/____/_____
2. Immunization: Engerix-B
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____

OR Quantitative Hepatitis B Surface Antibody lab test (attach lab reports)

Date ____/____/_____

C. VARICELLA

1. Immunization
   a. Dose #1 .#1 ____/____/_____
   b. Dose #2 given at least 12 weeks after first dose age 1–12 years. #2 ____/____/_____
   OR provide lab tests indicating immunity to varicella/Varicella IgG positive titer (attach lab report).

History of disease not accepted.

D. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

For all students under 22 years old. One dose after 16 years of age

1. Quadrivalent conjugate
   a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/_____

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E. TETANUS, DIPHTHERIA, PERTUSSIS

Td or Tdap required within last ten years – one Tdap required after age 11

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____

2. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____

RECOMMENDED VACCINATIONS - BUT NOT REQUIRED

A. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) __ routine ____outbreak –related

   a. Dose #1 ____/____/_____ __ b. Dose #2 _____/____/_____ __

OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related

   a. Dose #1 _____/____/_____ __ b. Dose #2 ____/____/_____ c. Dose #3 _____/____/_____

B. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 _____/____/_____ b. Dose #2 ____/____/_____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 _____/____/_____ _b. Dose #2 _____/____/_____ _ c. Dose #3 _____/____/_____

C. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known)

Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/_____ _ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____

D. COVID-19

Date of last dose: ____/____/_____

Other Vaccines not listed (BCG, Pneumovax, Typhoid, Yellow Fever, etc.)

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____)_____

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Parental Consent to Treat a Minor

Georgia law states that under most circumstances, parents or guardians must consent to have students less than 18 years of age receive treatment. In order to allow your Scottie the privilege of utilizing the Wellness Center Health Services at their convenience, we need your written consent.

I hereby authorize healthcare providers at Agnes Scott College Wellness Center, their agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while enrolled as a student at Agnes Scott College.

I hereby consent to such counseling services as may be requested by my minor ward or child.

_____ _____

Printed Name of Student Student's Date of Birth

_____

Student's Agnes Scott College ID Number

_____

Printed Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian MM/DD/YYYY

Appendix A

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever had close contact with persons known or suspected to have active TB disease? ❑ Yes ❑ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below.) ❑ Yes ❑ No

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Congo (Democratic Republic of)
Cote d'Ivoire
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea (Democratic People's Republic of)
Korea (Republic of)
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania (United Republic of)
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with average incidence rates of ≥ 20 cases per 100,000 population.

Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? (If yes, CHECK the countries or territories, above)	❑ Yes ❑ No
Have you been a resident, volunteer, and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?	❑ Yes ❑ No
Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?	❑ Yes ❑ No
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 using drugs or alcohol?	❑ Yes ❑ No

If you answered YES to any of the above questions, Agnes Scott College **requires** that you receive TB testing prior to your arrival to campus of your first enrolled term. The significance of any travel exposure should be reviewed with a health care provider.

If the answer to all the above questions is NO, no further testing or further action is required.

Part II. Clinical Assessment by Health Care Provider

Clinicians should review and verify the information in Part I. Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) **Yes_____ No**

History of BCG vaccination? (If yes, consider IGRA if possible.) **Yes_____ No**

1. TB Symptom Check

Does the student have signs or symptoms of active pulmonary tuberculosis disease? Yes _____No

If no, proceed to 2 or 3.

If yes, check below:

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

Proceed with additional evaluation to exclude active tuberculosis disease including chest x-ray (PA and lateral) and sputum evaluation as indicated.

2. Interferon Gamma Release Assay (IGRA)

Date Obtained:_____/_____/_____ (specify method) QFT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

Date Obtained: _____/_____/_____ (specify method) QFT T-Spot other_____
M D Y

Result: negative___ positive___ indeterminate___ borderline___ (T-Spot only)

3. 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_____

Date Given:_____/_____/_____ (M D Y) Date Read:_____/_____/ (M D Y)

Result: __mm of induration **Interpretation: positive_____negative_____

****Interpretation guidelines:**

Equal to or greater than 5 mm is positive:	● 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 and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.) ● HIV-infected persons
Equal to or greater than 10 mm is positive:	● Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time ● Injection drug users ● Mycobacteriology laboratory personnel ● Residents, employees, or volunteers in high-risk congregate settings ● Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight **The significance of the travel exposure should be discussed with a health care provider and evaluated.*
Equal to or greater than 15 mm is positive:	● Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

4. Chest x-ray: (Required if IGRA or TST is positive. Note: a single PA view is indicated in the absence of symptoms.**)**

Date of chest x-ray: _____/_____/_____ (M D Y) Result: normal____ abnormal____

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FAQs for Health Entrance Requirements (1/2)

Q: What is Med+Proctor?
A: Med+Proctor is a third-party company who the Wellness Center has partnered with for immunization compliance.

Q: Am I required to use Med+Proctor?
A:https://support.medproctor.com/am-i-required-to-use-medproctor/?hsCtaTracking=b7ab83c9-2f9b-43ed-8f7f-d6245e4bbf90%7Cc4178c94-254f-418a-bd96-18a1df045fe0

Q: If I have started a vaccine series, can I enroll and begin classes as long as I have the first dose?
A: Yes; as long as you have at least one dose and your second dose is not yet due, you are able to attend classes.

Q: Where can I receive an immunization I am missing?
A: Contact your healthcare provider, local pharmacy, or local health department to request receiving a vaccine you are missing.

Q: What if my immunization records are in another language?
A: If your records are in another language Med+Proctor will translate the information.

Q: What if I'm having trouble finding a copy of my immunization records?
A: Try asking your pediatrician or primary care provider or state health department. (https://www.cdc.gov/vaccines/programs/iis/contacts-locate-records.html).

Q: Do both graduate and undergraduate students have to get a physical?
A: No; only undergraduate students are required to have a physical within one year of arriving on campus.

Q: Does the medical exam form that is included in the entrance health requirements packet have to be filled out?
A: No; the medical exam form is there for convenience. If your provider has their own form they prefer to fill out, or if they prefer to give you a visit summary, that is acceptable -- as long as your name and DOB are included on the original document -- and can be uploaded to Med +Proctor.

Q: Is the TB screening questionnaire required?
A: Yes, the TB screening questionnaire is required. The form is included with the entrance health requirements packet. The screening must have been completed within the last 12 months. If further testing is indicated, it must also have been completed within the last 12 months.

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FAQs for Health Entrance Requirements (2/2)

Q: I had a meningococcal ACWY vaccine when I was twelve years old. Why does that dosage not count toward compliance?
A: You need a dose on or after your sixteenth birthday to be considered compliant.

Q: What if I'm pregnant or cannot receive a required immunization for another medical reason?
A: Consult your healthcare provider for guidance. If your provider recommends you do not receive the vaccine, please have them complete a medical exemption waiver request form. Please upload the form to Med+Proctor and email wellnesscenter@agnesscott.edu after doing so.