BRYN MAWR COLLEGE

Health Services
101 North Merion Ave Bryn Mawr, PA 19010
Phone: 610-526-7360
Website: https://www.brynmawr.edu/inside/offices-services/health-wellness-center

Student ID: ____________________________________
Student Cell Phone: __________________________
Send us a message: nurse@brynmawr.edu
Student Medical Portal: brynmawr.medicatconnect.com

Physical Examination Form

Last Name: ______________________First Name ________________________ Preferred Name______________ Date of Birth:_____

Instructions

The student named above has been admitted to Bryn Mawr College. While in attendance at Bryn Mawr, the student may receive health care services in Health Services. Is it beneficial for Health Services to have knowledge of the student's current and past medical history. In addition, the student's immunization history must be up to date. ***Providers are asked to complete, sign, and return this form to the student. Students are asked to upload the form to the Bryn Mawr College Student Medical Portal (brynmawr.medicatconnect.com) by July 1 for Undergraduate students & June 1 for Postbacs. Failure to submit a completed Health Record will result in the inability to register for the next semester classes.***

Health Conditions

Is this student currently under treatment for any medical or mental health condition? If yes, please include the condition and treatment plan:

Has this student suffered any major illness or injury in the past that we should be aware of?

Do you have any recommendations for this student’s health care while at Bryn Mawr College?

Physical exam must be within 365 days prior to July 1st

Date of Physical Exam: ________ Height: ________ Weight: _______ Blood Pressure: ________ Pulse: ________.

General	WNL	Remarks:		Breasts	WNL	Remarks:	
HEENT	WNL	Remarks:		Abdomen	WNL	Remarks:	
Thyroid	WNL	Remarks:		GU	WNL	Remarks:	
Neck	WNL	Remarks:		Musculoskeletal	WNL	Remarks:	
Lungs	WNL	Remarks:		Pelvic *(If indicated)*	WNL	Remarks:	
Cardio	WNL	Remarks:		Neurological	WNL	Remarks:	

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Allergies

Please list all allergies to medications, foods, and other known reactions.
(If the student has no known allergies, please check the box below.)

- ❑ The student has no known allergies to medications.
- ❑ The student has no known allergies to foods.

Medication(s):

Food(s):

Do they have an EpiPen?	❑ Yes	❑ No	Reason:

Current Medication

(List of all prescription and nonprescription medications, including vitamins & herbal supplements, including dose and times per day.)

Name	Dose	Frequency	Related Diagnosis

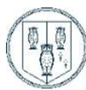
Fit for Sport

(This section is MANDATORY, physical will not be considered complete until completed by clinician)

Is this student medically qualified to participate in intercollegiate, intramural or club sport activities? Yes _____ No _____
If no, please explain why: ____
____
____

Signature of Provider: ______________________ Printed Name : ________________________ Date Of Completed Exam: __________

Mailing Address: ____ Office Phone : ____________________



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IMMUNIZATION RECORD
Student Name: ______________________________
Student ID: ______________________________
Date of Birth: ______________________________
Cell Number: ______________________________

Vaccine Requirements for First Year, Transfer and Postbac Students

The Commonwealth of Pennsylvania and Bryn Mawr College require full-time students to be immunized against certain communicable diseases or submit qualified vaccine waiver/exemption form. All dates must include month, day and year. *To comply, you must upload official documentation from your health care provider's office in addition to, manually inputting the dates for required vaccine under the "immunization tab" on the Student Health Portal at Brynmawr.medicatconnect.com*

Required Vaccines	Dosage Requirements	Date(s) of Vaccination
Meningitis A,C,W,Y (Meningococcal Quadrivalent)	One dose **ON OR AFTER AGE 16**	______/________/________ Month/day/year
MMR (Measles, Mumps, & Rubella) laboratory evidence of immunity is acceptable	Dose #1 **MUST** be given on or after 1st birthday Dose #2 **MUST** be given greater than 28 days after the first dose	MMR #1 _______/________/_________ Month/day/year MMR #2 _______/________/_________ Month/day/year
Polio – IPV	Series of 4 doses. Please provide the last date of primary series or booster	Dose #4/Booster _____/______/_______ Month/day/year
Tdap (Tetanus, Diphtheria, Pertussis)	One dose within the past 10 years	_______/__________/__________ Month/day/year
Varicella: laboratory evidence of immunity is acceptable in lieu of immunization or history of chicken pox	Dose #1 **MUST** be given on or after 1st birthday Dose #2 **MUST** be given greater than 28 days after the first dose	Dose #1 ______/________/________ Month/day/year Dose #2 ______/________/________ Month/day/year

Recommended /Additional Vaccines		Date(s) of Vaccination
Covid-19 Vaccine & Booster		
HPV (Human Papillomavirus)	2 or 3 dose Series	
Hepatitis A	2 doses at least 6 months apart	
Hepatitis B	3 doses	
Meningitis B	2 dose Series	
Typhoid		
Yellow Fever		

PROVIDER: PLEASE PROVIDE STUDENT WITH OFFICIAL DOCUMENTAION OF IMMUNIZATION RECORD &/or Record Dates in Spaces Provided Above

____

Clinician's Signature Date

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Tuberculosis Screening Questionnaire

Tuberculosis screening questionnaire must be completed by all students within 12 months of enrollment.

This form must be signed by a healthcare provider

Did you ever have BCG vaccine as a child?	No	Yes	Unsure
Have you ever had close contact with people known or suspected to have active TB disease?	No	Yes	
Were you born in or have ever lived, worked or visited for more than one month In a country with a high TB rate? (High prevalence countries are any countries other than the United States, Canada, Australia, New Zealand, and those in Northern & Western Europe?	No	Yes	
Have you been a health care worker, volunteer, resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, homeless shelter?	No	Yes	
Have you been a member of any of the following groups that may have increased incidence of latent M. tuberculosis infection or active TB disease – medically underserved, low income or abusing drugs or alcohol?	No	Yes	
Does the student meet Low Risk Criteria? (All questions above are answered NO)	No	Yes	

____ ________________

Clinician's Signature Date

Persons answering YES to any of the questions are candidates for EITHER the Mantoux tuberculin skin test (PPD) OR Interferon Gamma Release Assay (IGRA) blood test.

Tuberculin Skin Test (PPD): Result should be recorded as actual millimeters of induration

Date Given: _________________ Date Read: _________________Result: _______ mm induration

Interferon Gamma Release Assay (IGRA)

Date Obtained ______________ Specify Method: _______ QFT-GIT ________ T-Spot

Result: ______ Negative _______Positive _______Indeterminate _________ (T-Spot only)

Chest X-Ray: Required if PPD or IGRA is POSITIVE

Date of chest x-ray __________________ Result: _____________ Normal ______________ Abnormal

Recommended treatment for Positive PPD or IGRA: ____

Clinician's Signature Date