Dear Student and Parent(s),

The Health Center welcomes you to Moravian College.

Enclosed are the health information documents that students must complete and return to the Health Center before beginning studies at Moravian. The documents include:

- **Report of Physical Examination and Family and Personal Medical history.** Completion of these forms is required of all students (freshmen and transfers). These two forms must be signed by the health care provider.
- **Immunization record.** Required of all students. It must be completed and signed by the health care provider.
- **Tuberculosis screening questionnaire.** All students are required to answer a few simple questions regarding their risk for tuberculosis. The questionnaire must be signed by the student and reviewed and signed by the student’s health care provider. If needed, a TB screen must be done.
- **Consent for treatment and health insurance information form.** Must be filled out and signed by the student and by the student’s parent or guardian if the student is under 18. Include a copy of both front and back of the student’s insurance card (or parents’ insurance card, if insurer does not issue a separate card for dependents).
- **Meningitis medical waiver and release form.** Meningitis is a very serious illness and it is important to protect yourself. If you decide not to be vaccinated against Meningococcal disease, you must sign the declination statement and return the form to the Health Center. If you are under 18, your parent or guardian must also sign it.

I would like to call your attention to the required immunization form. These immunization requirements are in keeping with the recommendations of the following organizations: the American College Health Association (www.acha.org) and the Centers for Disease Control’s Advisory Committee in Immunization Practices (www.cdc.gov/vaccines/acip). It is important to discuss these recommendations with your health care provider. Older students (over 30) and those living off campus can be excused from the Meningococcal vaccine requirement but must still sign the waiver form.

Most care at the Health Center is free, including physician visits and over-the-counter medications. We also do minor lab testing on site and have a limited number of prescription drugs for which there is a minimum charge. However, outside lab work, specialist referrals, and prescription medications referred to outside facilities are the students’ responsibility. Many providers will bill insurance companies directly.

Again, the **completed forms** must be submitted to the Health Center with the rest of your Admission forms. It is imperative that your health care provider sign at the end of each form where indicated. If you have any questions, please do not hesitate to contact me at 610 861-1567, fax 610 625-7899. I look forward to meeting you and wish you a successful experience at Moravian College.

Sincerely,

**Stephanie Dillman RN BSN**

Stephanie Dillman RN BSN  
Health Center Coordinator  
Dillmans@moravian.edu
MORAVIAN COLLEGE HEALTH CENTER
FAMILY AND PERSONAL MEDICAL HISTORY

YOU HAVE BEEN ACCEPTED. The information you provide is used solely as an aid in providing health care, if necessary, while you are a student.

The only information released will be the fact that your form was/was not received and that your immunizations are complete/incomplete. No other information will be released without your knowledge and consent.

1. Please complete this form AND TAKE WITH YOU WHEN going to your health care provider for examination. 2. Please print clearly in black ink.

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>Middle name</th>
<th>Date of birth</th>
<th>Gender</th>
<th>Social Security Number</th>
<th>expected grad year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s home address (street and number)</td>
<td></td>
<td></td>
<td></td>
<td>City</td>
<td>State</td>
<td>Zip code</td>
</tr>
<tr>
<td>Name and relationship of next of kin (e.g., parents)</td>
<td></td>
<td></td>
<td></td>
<td>Relationship to student</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address of next of kin</td>
<td></td>
<td></td>
<td></td>
<td>Home phone</td>
<td>Business phone</td>
<td>Relationship to student</td>
</tr>
</tbody>
</table>

FAMILY HISTORY If you have more than two siblings, please attach an additional sheet.

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Year and Cause of Death</th>
<th>Have any of your relatives ever had:</th>
<th>Yes</th>
<th>Relationship</th>
<th>Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td>Cancer (type)</td>
<td>Diabetes mellitus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>Epilepsy/seizures</td>
<td>Gastrointestinal disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td>Asthma</td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Siblings</td>
<td>Heart disease</td>
<td>Mental health issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Environmental allergy:</td>
<td>Nephritis/other kidney disease</td>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PERSONAL HISTORY Please check any issue that you currently have or have had in the past.

| Food allergy: | Kidney stones |
| Medication allergy: | Urinary tract infection |
| Environmental allergy: | Asperger’s syndrome/autism |
| DERMATOLOGIC (SKIN) | Yes |
| ACUTE | CARDIOVASCULAR (HEART) | Yes |
| GENITOURINARY | FEMALES ONLY | Yes |
| NEURO/PSYCHIATRIC | Severe head injury |
| Asthma | Heart palpitations (painful periods) |
| Environmental allergy: | Asperger’s syndrome/autism |
| EYE/ENT/RESPIRATORY | High blood pressure |
| Ophthalmic problems | Pregnancy |
| Glasses or contacts | Low blood pressure |
| Eating disorder anorexia/bulimia | Severe head injury |
| Personal history | MALES ONLY |
| Personal history | Alcohol or other drug use |
| Personal history | ADD/ADHD |
| Personal history | Psychotherapy |
| Personal history | INFECTIONOUS DISEASES |
| Personal history | HIV (genital warts) |
| Personal history | HPV (genital warts) |
| Personal history | Other surgery (specify below) |
| Personal history | GASTROINTESTINAL |
| Personal history | Appendectomy |
| Personal history | Diabetes (specify type below) |
| Personal history | Eating disorder anorexia/bulimia |
| Personal history | Tonsillectomy |
| Personal history | Thyroid disorder (specify below) |
| Personal history | Other surgery (specify below) |

Please explain all positive responses and give requested specifications here. What other health issues should we know about? OPTIONAL: Is there any physical disability with which you will require assistance while a student at Moravian College? Attach an additional sheet if necessary.

Please list all medications taken routinely.

Student's Signature | Date |
|--------------------|------|

Health Care Provider's Signature (acknowledging review) | Date |

PAGE 1
Student's Name ___________________________ Date of birth __________________________

TO THE EXAMINING HEALTH CARE PROVIDER: This student has been accepted. Please review the student's history and complete this examination with comments on any disease or defects. Physical exam must be done less than one year prior to first day of classes.

<table>
<thead>
<tr>
<th>Blood pressure</th>
<th>Pulse</th>
<th>Height (in.)</th>
<th>Weight (lbs.)</th>
<th>BMI</th>
<th>Urinalysis</th>
<th>Visual acuity</th>
<th>Corrected?</th>
<th>Gross hearing</th>
</tr>
</thead>
</table>

CLINICAL EVALUATION

<table>
<thead>
<tr>
<th>Normal</th>
<th>IF Abnormal please describe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
</tr>
<tr>
<td>Head and scalp</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears/hearing</td>
<td></td>
</tr>
<tr>
<td>Mouth, nose, throat</td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
</tr>
</tbody>
</table>

1. Any known impaired function and/or loss of any paired organ?  □ Yes  □ No  If yes, specify ________________________________
2. Allergies or contraindications to any medication?  □ Yes  □ No  If yes, specify ________________________________
3. Any medicine taken on a regular basis?  □ Yes  □ No  If yes, specify ________________________________
4. Recommendation for physical activity:  □ Unlimited  □ Limited; explain _______________________________________________
5. Can this individual participate in intercollegiate athletics, including contact sports?  □ Yes  □ No
6. **Sickle-cell trait blood test is mandated by NCAA for all athletes. Does this individual carry the sickle-cell trait?**  □ Yes  □ No
7. General comments or recommendations: ________________________________________________________________

TUBERCULOSIS RISK ASSESSMENT: All students must be assessed for Tuberculosis, based on that assessment TB testing may need to be completed. Please see the very specific Tuberculosis screening tool on pages 4, 5 and 6.

If you are planning on participating in any campus NCAA Sporting teams please make a copy of this form (Report of Physical Exam) and forward to Bob Ward C/O Moravian College Athletics - 1200 Main Street, Bethlehem, Pa 18018
MORAVIAN COLLEGE HEALTH CENTER
IMMUNIZATION RECORD

Student’s Name ________________________________ Date of birth _______________________

This form must be completed and signed by the health care provider.
Moravian College’s immunization policy is in compliance with the recommendations of the Pennsylvania Department of Health.
IF YOU ARE ATTACHING RECORDS PLEASE MAKE SURE THEY FIT THE REQUIREMENTS BELOW!

Meningococcal Disease REQUIRED
Pennsylvania state law requires ALL students residing in a dormitory or campus housing either to receive the Meningococcal vaccine OR to sign a declination statement after review of written information stating the benefits of receiving the vaccine.

1. Quadrivalent conjugate (Menactra or Menveo) preferred
   Date #1 ___/___/___ #2 ___/___/___
   (Was the student 16 or older at the time of this vaccine? IF NO- PLEASE give booster dose and document)
   At least 1 dose of conjugate after 16 years of age

2. Quadrivalent polysaccharide (Menomune) acceptable alternative if conjugate not available.
   Date ___/___/___

Meningitis B Vaccine NEW VACCINE STRONGLY ENCOURAGED: (please specify type) Bexsero #1 _/__/__ #2 _/__/__
   OR Trumebba #1 _/__/__ #2 _/__/__ #3 _/__/__

Varicella (Chicken Pox) REQUIRED
Requirement is met by a history of chicken pox, a positive varicella antibody, OR two doses of vaccine.

1. History of disease ❑ Yes ❑ No - if no disease needs 2 doses of vaccine. Age at time of disease ______

2. Immunization (2 doses of vaccine)
   a. Dose #1 Date #1 ___/___/___
   b. Dose #2, given at least 12 weeks after first dose, ages 1-2 years and at least 4 weeks after first dose if age 13 years or older Date ___/___/___
   OR #2 ___/___/___

3. Varicella antibody Date ___/___/___ Result: ❑ Reactive ❑ Nonreactive: If non-reactive please vaccinate and document

MMR (Measles, Mumps, Rubella) REQUIRED: Two doses required at least 28 days apart. IF NO VACCINE RECORDS: IGG titers can be ordered/documentd

1. Dose 1, given at age 12 months or later #1 ___/___/___ #2 ___/___/___

2. Dose 2, given at least 28 days after first dose #1 ___/___/___ #2 ___/___/___


Tetanus, diphtheria, pertussis REQUIRED

1. Primary series of four doses with DTaP,DTP,DT or Td #1 ___/___/___ #2 ___/___/___
2. Booster including Pertussis using Tdap version within 10 years (Tdap recommended for ages 11-64 unless contraindicated) Booster date ___/___/___ this must be a Tdap/Adacel/Boostrix booster #3 ___/___/___ #4 ___/___/___

Hepatitis B REQUIRED
Requirement is met by three doses of vaccine OR a positive hepatitis B surface antibody.

1. Hepatitis B vaccine only Dates #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
2. Combined hepatitis A and B vaccine Dates #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
3. Hepatitis B surface antibody Date ___/___/___ Result: ❑ Reactive ❑ Nonreactive:

Polio REQUIRED Primary series (OPV or IPV)

Dates #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___

Human Papilloma virus RECOMMENDED
Three doses of vaccine recommended for female or male college students 11-26 years of age, given over 6 months.
Indicate preparation: Quadrivalent (Gardasil) Bivalent (Cervarex)

Hepatitis A RECOMMENDED Hepatitis A vaccine

EXEMPTIONS: Exemption to any of the immunization requirements can be granted to students who provide a note or letter signed by a licensed health care provider stating the medical reason why the student should not or need not receive the vaccine or a statement signed by the student or by the parent/guardian if the student is less than 18 years of age, that the immunization(s) is against his or her personal beliefs.

MD DO NP PA

Name of Health Care Provider ___________________________ Street Address ___________________________

Signature of Health Care Provider ___________________________ Date ___________________________ City, State, Zip ___________________________ Phone ___________________________
Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by ALL incoming students)

Please complete and take with you to your Health care provider for review and signature.

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 listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)  □ Yes  □ No

Afghanistan  Bangladesh  Botswana  Brazil  Brunei Darussalam  Bulgaria  Burkina Faso  Burundi  Cabo Verde  Cambodia  Cameroun  Central African Republic  Chad  China  Colombia  Comoros  Congo


Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2012. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://apps.who.int/ghodata.

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB disease? (If yes, CHECK the countries, above)  □ Yes  □ No

Have you been a resident 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 abusing drugs or alcohol?  □ Yes  □ No

If the answer is YES to any of the above questions, Moravian College requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester).

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

*The significance of the travel exposure should be discussed with a health care provider and evaluated.
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. **IF PART I is negative for risk- STOP HERE.**

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 (hemoptyis)
- Chest pain
- 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.

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: ____/____/____  Date Read: ____/____/____

M     D       Y  M     D      Y

Result: ________ mm of induration  **Interpretation: positive____ negative____

Date Given: ____/____/____  Date Read: ____/____/____

M     D       Y  M     D      Y

Result: ________ mm of induration  **Interpretation: positive____ negative____

**Interpretation guidelines

>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

>10 mm is positive:

- Recent arrivals to the U.S. (<5 years) 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.

>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.

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

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____          (specify method)    QFT-GIT     T-Spot     other_____

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

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

Date of chest x-ray: ____/____/____   Result: normal____ abnormal_____

Part III. Management of Positive TST or IGRA

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB with appropriate medication. However, students in the following groups are at increased risk of progression from LTBI to TB disease and should be prioritized to begin treatment as soon as possible.

🧧 Infected with HIV
🧧 Recently infected with *M. tuberculosis* (within the past 2 years)
🧧 History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
🧧 Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to/greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
🧧 Diagnosed with silicosis, diabetes mellitus, chronic renal failure, leukemia, or cancer of the head, neck, or lung
🧧 Have had a gastrectomy or jejunoileal bypass
🧧 Weigh less than 90% of their ideal body weight
🧧 Cigarette smokers and persons who abuse drugs and/or alcohol

**Populations defined locally as having an increased incidence of disease due to *M. tuberculosis*, including medically underserved, low-income populations**

_____Student agrees to receive treatment
_____Student declines treatment at this time

_________________________________________________________

[Health Care Provider Signature]  [Date]

COMMENTS:  
________________________________________________________

[Comments]

page 6
MORAVIAN COLLEGE HEALTH CENTER
CONSENT FOR TREATMENT

Permission must be obtained before medical treatment can be rendered. The following consent form should be signed by the student so that indicated care may be given with no unnecessary delay. Please check the word “give” in both places in which it occurs. In the event that you do not want treatment rendered under any circumstance, check the word “refuse” instead, in both places. If the form is not signed, it will be interpreted as a refusal of permission. Must be completed by student/parent if under 18:

I q GIVE q REFUSE permission to the health care providers of Moravian College to treat any illness or injury and to carry out such diagnostic and therapeutic procedures as may be necessary for myself/my son/daughter (print name) ___________________________ and, in their absence, to the nurse on duty to render emergency care and other medical care in line with standing orders.

I also q GIVE q REFUSE permission for such procedures to be carried out at and by one of the local hospitals in the event that I have been sent or taken there for emergency care.

Signature of student/parent guardian ____________________________
Printed name ____________________________ Date ___________

HEALTH INSURANCE INFORMATION

It is REQUIRED that every student have primary health insurance coverage. Please attach copies of health and pharmacy insurance cards (front and back).

It is your responsibility to maintain current insurance information at the Health Center throughout your college career. It is also your responsibility to understand your health insurance plan (such as referral information, laboratory information, and in-network providers within the Bethlehem area). Students assume the cost of healthcare not provided by the Health Center. These include radiology and laboratory services (such as blood work and all cultures) and any outside health care provider evaluations.

Name of Subscriber ____________________________ Subscriber’s Date of birth ___________
Relationship to student ____________________________

Name of Insurance company ____________________________ Insurance company telephone ____________________________

Group number ____________________________ ID Number ____________________________

Name of Primary Care Physician (PCP) ____________________________ PCP telephone number ____________________________ PCP Fax ____________________________

Are you a member of a Health Maintenance Organization (HMO)? q Yes q No
Do you have out-of-network coverage? q Yes q No

Is a health insurance referral required for evaluations by specialists OR Radiology services? q Yes q No

Does your health insurance require the use of a specific laboratory for laboratory services? q Yes q No

If “Yes,” please indicate laboratory to be used: q St. Luke’s University Hospital q Quest Diagnostics q Lab Corp q Other ____________________________

MORAVIAN COLLEGE HEALTH CENTER
MENINGITIS MEDICAL WAIVER AND RELEASE FORM

Student’s Name ____________________________ Date of birth ___________

Pennsylvania law requires colleges and universities to inform students about meningitis. The law also requires students to either receive the vaccination OR sign a waiver that they have read the information provided inclusive of risks but decided not to receive the vaccination for religious or other reasons.

Students 18 years of age and older must complete. If you are under 18 and you want to waive the meningitis vaccine, your parent must sign the waiver. I ____________________________, certify that I am an adult individual 18 years of age or older or certify that I am the parent of a minor or legal guardian of __________________________ (“Student”). I further certify that I have been provided with written information via electronic link to Moravian College Health Center website explaining the risks associated with Meningococcal disease, and the availability and effectiveness of vaccination against the disease and I have reviewed this information. Notwithstanding the information provided, for religious or other reasons, I choose not to be vaccinated/not to have the Student vaccinated against Meningococcal disease. I acknowledge that I am making the decision not to be vaccinated with the full realization that there may be a significant risk of bodily harm, including death, if I/Student contracts the disease. I hereby assume all the risks associated with my decision not to be vaccinated/not to have the student vaccinated and agree to release and hold harmless Moravian College, its trustees, officers, agents, and employees, from any and all liability, actions, causes of action, negligence, debts, claims, or demands of any kind and nature whatsoever including, but not limited to, claims for negligence, recklessness or any other form of action for which a release may be legally given (including attorneys’ fees and costs) which may arise by or in connection with my decision. I agree further to hold harmless and indemnify the College, its trustees, officers, agents and employees from any and all liability, actions, causes of action, negligence, debts, claims, or demands of any kind and nature whatsoever including, but not limited to, claims for negligence, recklessness or any other form of action for which a release may be legally given (including attorneys’ fees and costs) by any person or the College which may arise by or in connection with my decision not to be vaccinated. I hereby certify that I voluntarily sign this waiver and release, and intend to be legally bound by the terms of this document. I have read all of its provisions, and fully understand its significance. I further understand that by State law I will not be allowed to reside in College owned housing unless I have either received the vaccine or declined the vaccine by completing the verification/waiver form.

PLEASE CHECK ONE OF THE FOLLOWING STATEMENTS AND SIGN:

___ I HAVE been vaccinated on or after my 16th birthday per the requirements and require no further vaccination

___ I DECLINE the vaccine

___ I decline the vaccine at this time but may wish to have it at a later date

Signature of Student/Parent ____________________________ Date ____________
Printed name ____________________________