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 (_____)_____

AGNES SCOTT
COLLEGE

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. COVID-19* (*see FAQ Sheet)

1. Immunization (COVID-19)
   a. Dose #1: ___/___/_____ Manufacturer Name: _____ (MM DD YYYY)
   b. Dose # 2: ___/___/_____ Manufacturer Name: _____ (n/a if Dose #1 was J&J/Janssen) (MM DD YYYY)
   c. Booster Dose #1: ___/___/_____ Manufacturer Name: _____ (MM DD YYYY)
   d. Bivalent Dose: ___/___/_____ Manufacturer Name: _____ (MM DD YYYY)

B. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later .....#1 ___/___/_____ (MM DD YYYY)
2. Dose 2 given at least 28 days after first dose .....#2 ___/___/_____ (MM DD YYYY)

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

C. HEPATITIS A

1. Immunization (hepatitis A)
   a. Dose #1 ___/___/_____ (MM DD YYYY) b. Dose #2 ___/___/_____ (MM DD YYYY)
2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ___/___/_____ (MM DD YYYY) b. Dose #2 ___/___/_____ (MM DD YYYY) c. Dose #3 ___/___/_____ (MM DD YYYY)

D. HEPATITIS B

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

1. Immunization: Heplisav-B
   a. Dose #1 ___/___/_____ (MM DD YYYY) b. Dose #2 ___/___/_____ (MM DD YYYY) c. Dose #3 ___/___/_____ (MM DD YYYY)
2. Immunization: Engerix-B
   a. Dose #1 ___/___/_____ (MM DD YYYY) b. Dose #2 ___/___/_____ (MM DD YYYY)

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

Date ___/___/_____ (MM DD YYYY)

E. VARICELLA

1. Immunization

a. Dose #1 .....#1 ___/___/_____
MM DD YYYY

b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. .....#2___/___/_____
and at least 4 weeks after the first dose if age 13 years or older. MM DD YYYY

OR provide lab tests indicating immunity to varicella/Varicella IgG positive titer (attach lab report). History of disease not accepted.

F. 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 ___/___/_____
MM DD YYYY MM DD YYYY

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ___/___/_____
MM DD YYYY

G. 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: ___/___/_____
MM DD YYYY

2. Date of most recent booster dose: ___/___/_____ Type of booster: Td _____ Tdap _____
MM DD YYYY

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 ___/___/_____
MM DD YYYY MM DD YYYY

OR

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

a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____ c. Dose #3 ___/___/_____
MM DD YYYY MM DD YYYY MM DD YYYY

B. 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 ___/___/_____
MM DD YYYY MM DD YYYY MM DD YYYY

C. POLIO

Completed primary series: Oral _____ or Inactivated _____

Dose of last dose: ___/___/_____
MM DD YYYY

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

HEALTH CARE PROVIDER INFORMATION

Name _____ Signature _____ Date ___/___/_____

Address _____ Phone (_____)_____

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

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 abusing 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 the start 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:_____/_____/_____ 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:	• 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.*
>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: _____/_____/_____ Result: normal____ abnormal____
M D Y

Part III. Considerations for Treatment of LTBI

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infection, the likelihood of progression to active tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active 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 and e-cigarette smokers and persons who abuse drugs and/or alcohol

AGNES SCOTT
COLLEGE

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

AGNES SCOTT
COLLEGE

FAQs for Health Entrance Requirements

Q: Which of the COVID vaccines are required?
A: All incoming students are required to provide proof of a bivalent dose. If other doses were received, please include that information on the Immunization Form.

Q: Is a TB screening required?
A: Yes, a TB screening 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.

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: All immunization records and health entrance forms must be in English prior to submission.

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: 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: If I haven't started a vaccine series yet, 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. A future-dated hold will be placed on your account for the date your second dose is due. This process can be repeated until all doses in the series have been received.

Q: What does a "hold" mean?
A: A hold on your account from the Wellness Center means that you have not met one or more of the Entrance Health Requirements including, but not limited to, a vaccine, medical exam form, or the TB screening form.

AGNES SCOTT
COLLEGE

FAQs for Health Entrance Requirements

Q: What does a "future dated hold" mean?
A: A "future dated hold" means that you are still able to register and drop/add classes until the beginning date of the hold, however one or more requirements will be due in the future. Once the date arrives, it is a traditional hold, limiting your ability to register and drop/add classes. In order to avoid the hold becoming active, make sure to meet the requirement, upload proof to the Medicat portal, and enter a date if applicable before the start date of the future-dated hold.

Q: What if I'm pregnant and cannot receive a required immunization?
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 Medicat and email wellnesscenter@agnesscott.edu after doing so.