Dear Albright College Students:

Completion of Forms
Enclosed you will find a medical history and physical form, immunization record, forms for emergency contact information and medical insurance and the meningitis waiver (the waiver needs to be signed if you have not or will not be receiving the meningitis vaccine). If you are planning on participating in Albright College Athletics, please complete the appropriate forms pertaining to sickle cell trait testing. All forms must be completed and submitted to the Gable Health Center.

Your health care provider will complete the physical and immunization records. You and/or your parents will complete all other forms. If you have any questions, please do not hesitate to contact the Gable Health Center at (610) 921-7532.

Confidentiality
Confidentiality requirements contained in Federal regulations do not permit the College to disclose medical information pertaining to students/patients over the age of eighteen to anyone, including family members. Information about medical services rendered to you by the Health Center should be provided to others (parents and college personnel) directly by you.

Emergency
In case of an emergency, health center personnel will assist in facilitating the transportation of a student to a local hospital but cannot accompany students to the hospital. During evenings and weekends, other college personnel are available to assist in the transportation.

Insurance Coverage
It is important that you and your parents remain familiar with the coverage contained in your health insurance plan, especially if you are a member of a Health Maintenance Organization (HMO) or your place of residence is outside of Pennsylvania or the United States. Routine medical care for acute conditions and gynecological services are provided on a fee-for-service basis for each patient visit. The Health Center cannot accept insurance assignments but will furnish copies of bills for services rendered to students in order to seek reimbursement through their insurance carriers.

HMO participants are reminded that the Health Center is generally not their primary care provider, and should they require the services of a specialist, they will be asked to secure an appropriate referral from their primary care provider. Following the guidelines issued by your HMO will facilitate both the provision of and payment of medical care.

Thank you in advance for your prompt attention to this important process.

Sincerely,

Joshua Williamson, M.D.
College Physician
Gable Health Center

Samantha Wesner, MSN, CRNP, RNC
Assistant Dean of Students and Director of the
Gable Health Center
Sickle Cell Anemia

Sickle cell anemia is a recessive genetic blood disorder caused by a defect in the gene which codes for hemoglobin. The defective gene is called hemoglobin S, which changes the shape of the red blood cells from circular to crescent- or sickle-shaped. With this change in shape, the red blood cells deliver less oxygen to the body’s tissues and there is an increased chance of the cell getting caught in the small blood vessels and breaking apart; both of which can interrupt blood flow. These issues will decrease the amount of oxygen flowing to the tissues.

Being a recessive genetic disorder, sickle cell is shown when both parents have the disorder, one parent has the disorder and the other is a carrier (known as sickle cell trait), or both parents are carriers for the disorder. People with the trait do not have the symptoms of sickle cell anemia but have the ability to pass the disorder to their children.

Sickle cell anemia is most common among people of African and Mediterranean descent. It is also common in people from South American or Central American countries, the Caribbean and the Middle East. In the United States, it affects around 72,000 people, most of whom have ancestors from Africa. About 2 million Americans, or 1 in 12 African Americans, carry the sickle cell trait.

The disorder’s course does not follow a single pattern; some patients may have mild symptoms, while others have severe symptoms which can require hospitalization. The symptoms occur in painful episodes, called crises, which can last from hours to days. Crises can cause pain the bones of the back, long bones, and the chest.

In a severe crisis, the following symptoms may be experienced:

- Fatigue
- Paleness
- Rapid heart rate
- Shortness of breath
- Jaundice (yellowing of the eyes and skin)

If small blood vessels become blocked by the sickle-shaped cells, the following symptoms may occur:

- Priapism (painful and prolonged erection)
- Poor eyesight and blindness
- Problems thinking or confusion caused by small strokes
- Ulcers on the lower legs

Over time, the spleen no longer works and the following symptoms or infections can occur:

- Bone infection (osteomyelitis)
Sickle Cell Anemia Fact Sheet

- Gallbladder infection (cholecystitis)
- Lung infection (pneumonia)
- Urinary tract infection

The following other symptoms can occur:

- Delayed growth and puberty
- Painful joints caused by arthritis

Hemoglobin electrophoresis is the most common method of testing for sickle cell anemia. This blood test measures the different types of the oxygen-carrying protein (hemoglobin) in the blood. Each state began screening at different times; beginning with New York on April 1, 1975. Pennsylvania began testing in September 28, 1992. As of 2012, all states test newborn infants for sickle cell anemia.

There are many treatment options to reduce the number of crises. Folic acid supplements, which are needed to make new red blood cells, should be taken. Treatment options include:

- Blood transfusions
- Pain medicines
- Plenty of fluids
- Hydroxyurea: a medicine that may help reduce the number of pain episodes in some people

Treatments to manage possible complications due to sickle cell anemia include:

- Dialysis or kidney transplant for kidney disease
- Counseling for psychological complications
- Gallbladder removal in people with gallstone disease
- Hip replacement for avascular necrosis of the hip
- Surgery for eye problems
- Treatment for overuse or abuse of narcotic pain medicines
- Wound care for leg ulcers

Due to a better understanding and management of the disease, the prognosis for sickle cell anemia is better today than it was in the past. The most common causes for death due to sickle cell anemia include organ failure and infection.

The NCAA Division III recently updated their policy on testing for sickle cell anemia. It is now required that all athletes be tested for the trait or sign a written release declining the test before competing. This is new to Division III, but has been mandatory for Division I and II schools. There are many reasons for this change. People with sickle cell trait (they are carriers for the disorder) normally do not show symptoms of the disorder, however, there is still the
Sickle Cell Anemia Fact Sheet

possibility of experiencing severe reactions, including sudden death when severely dehydrated or during intense physical activity. The mandatory testing is to give coaches and athletic trainers awareness that some athletes may need to take precautions.

Sources:


SICKLE CELL TRAIT STATUS VERIFICATION FORM

Name: ________________________________  Sport: ________________________________

Date of Birth: ________________________  Year of Eligibility:  1  2  3  4

Student I.D. #: ________________________  Cell Phone #: __________________________

Local Address: _______________________

Please list the date of the Sickle Cell Trait testing: ____________________________

Please list the result of the Sickle Cell Trait Screen: Positive _____  Negative _____

If available: Hemoglobin electrophoresis result ______________

Are there any restrictions to participation:  No restrictions ___________

Restricted to __________________________

I verify that the above named individual has been tested for Sickle Cell Trait.

Signature of Health Care Provider: ________________________________

Date: _________________

Health Care Provider Printed Name: ________________________________

Address: ________________________________

Phone Number: ____________________________

SIGN AND RETURN ALL FORMS TO GABLE HEALTH CENTER

13th & BERN STREETS, READING, PA 19612  FAX 610-921-7590
Sickle Cell Trait Status Testing Waiver

I _________________ understand and acknowledge that:

(Student-Athlete Name)

I have read and fully understand the facts about sickle cell trait and sickle cell trait testing.

The NCAA recommends, and Albright College Athletics require, that all student–athletes have knowledge of their sickle cell trait status before participating in any intercollegiate athletic event, including strength and conditioning sessions, practice, and competitions.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Albright College Athletic Training Staff.

I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination and I agree to defend, hold harmless, indemnify and release the Board of Trustees of Albright College, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of personal injury or death which may result from my non-compliance with the recommendation of the NCAA and requirement of Albright College Athletics.

I have read this document and acknowledge that I understand its significance. I further state that I am at least 18 years of age and competent to sign this waiver, or that if I am under 18 years of age, I have the approval of my parents or guardian to sign this waiver as evidenced by their signature on this document.

__________________________  __________________________
(student-athlete name, please print)  (sport)

__________________________  __________________________
(student-athlete signature)  (date)

__________________________  __________________________
(parent/guardian signature, if under 18 years of age)  (date)

SIGN AND RETURN ALL FORMS TO THE GABLE HEALTH CENTER STAFF

13th AND BERN STREETS, READING, PA 19612  FAX 610-921-7590
Gable Health and Counseling Center
Consent for Medical Care and Emergency Treatment of a Minor

In presenting my son/daughter for diagnosis and treatment

Name: ____________________________ for ______________________________

☐ Mother ☐ Father ☐ Legal Guardian (name of student)

of _________ years of age, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, medical treatment and laboratory tests, by authorized members of the Gable Health Center staff or their designees, as may in their professional judgment be necessary.

I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my child’s condition.

I have read this form and certify that I understand its contents.

I hereby give my consent to: The Gable Health and Counseling Center who will be caring for my child to arrange for routine or emergency medical care and treatment necessary to preserve the health of my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered.

_________________________________________
Mother, Father, or Legal Guardian signature

__________________
Date

In case of emergency I can be reached at:

________________________________________________________________________
Gable Health and Counseling Center/Albright College Sports Medicine

Medical Insurance Information

Please complete the following information about the student.

Name: ___________________________________________
Social Security: _________________________________
Date of Birth: _________________________________
Home Address: __________________________________
Albright Campus Address: _______________________

city State Zip Code
city State Zip Code

Emergency Contact: _____________________________
Primary Care Physician: _________________________

Sport/s Participating In: _________________________

Please complete the following information about the cardholder (i.e. father/ mother) of your Medical Insurance. If you are not insured at this time, please write "not insured". *Athletes are required to have medical coverage*

 PRIMARY INSURANCE:  
 Card Holder Name: _____________________________
 Card Holder SS#: ______________________________
 Card Holder DOB: ______________________________
 Insurance Company Name: ______________________
 Insurance Company Address: _____________________
 Insurance Company Phone #: _____________________
 Group #: ____________________
 Identification #: ________________________________
 Is student insured under this policy? ______________
 Is this Policy an HMO / PPO? YES NO

 SECONDARY INSURANCE:  
 Card Holder Name: _____________________________
 Card Holder SS#: ______________________________
 Card Holder DOB: ______________________________
 Insurance Company Name: ______________________
 Insurance Company Address: _____________________
 Insurance Company Phone #: _____________________
 Group #: ____________________
 Identification #: ________________________________
 Is student Insured under this policy? ______________
 Is this Policy an HMO / PPO? YES NO

It is important that we have this information on a yearly basis. Please provide a copy of your insurance card (front and back) with this form. Athletes must have this information on file prior to first athletic practice session.
Gable Health and Counseling Center
IMMUNIZATION RECORD

PART I

Name  __________________________________________________   _____________________________________________________
First Name Middle Name
____________________________________________________________________________________________________________
Last Name
Address  ____________________________________________________________________________________________________________
Street City State Zip
Date of Entry ____/________          Date of Birth ____/____/________           School ID#  ___________________________________________
M             Y      M         D            Y
Status:          Part-time _____          Full-time _____          Graduate _____          Undergraduate _____          Professional

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)
(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

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

B. MENINGOCOCCAL QUADRIVALENT
(A, C, Y, W-135) One or 2 doses for all college students; revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/________     b. Dose #2 ____/____/________
      M        D           Y                    M         D           Y
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).
   Date ____/____/________
      M       D           Y

C. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed?     Yes ___     No ___    Date of last dose in series: ____/____/________
   Date of most recent booster dose: __/____/________
   Type of booster:     Td _____     Tdap _____
   Tdap booster recommended for ages 11-64 unless contraindicated
2. Date of most recent booster dose: __/____/________
   Type of booster:     Td _____     Tdap _____
   Tdap booster recommended for ages 11-64 unless contraindicated

D. HEPATITIS B
(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11–15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)
   a. Dose #1 ____/____/________     b. Dose #2 ____/____/________     c. Dose #3 ____/____/________
      M        D           Y                        M        D           Y             M        D           Y
     Adult formulation ___     Child formulation ___     Adult formulation ___     Child formulation ___     Adult formulation ___     Child formulation ___

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ____/____/________     b. Dose #2 ____/____/________     c. Dose #3 ____/____/________
      M        D           Y              M      D           Y                   M        D           Y

3. Hepatitis B surface antibody  Date __/____/________    Result: Reactive ________     Non-reactive ________
E. INFLUENZA
Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV3) _____ Live attenuated influenza vaccine (LAIV) _____
Date of last dose:  ____/____/_______

F. VARICELLA
(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)
1. History of Disease  Yes ___  No ___  or  Birth in U.S. before 1980  Yes ___  No ___
2. Varicella antibody  ____/____/________  Result:  Reactive ________  Non-reactive ________

3. Immunization
a. Dose #1  ____/____/________  M        D            Y
b. Dose #2 given at least 12 weeks after first dose ages 1–12 years  ____/____/________  and at least 4 weeks after first dose if age 13 years or older.

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2/HPV4/HPV9)
(Three doses of vaccine for females and males 11–26 years of age at 0, 1–2, and 6 month intervals.)
Immunization (indicate which preparation, if known)  Quadrivalent (HPV4) _____  or  Bivalent (HPV2) _____  or 9-valent (HPV9) _____
a. Dose #1  ____/____/________  b. Dose #2  ____/____/________  c. Dose #3  ____/____/________

H. HEPATITIS A
1. Immunization (hepatitis A)
a. Dose #1  ____/____/________

2. Immunization (Combined hepatitis A and B vaccine)
a. Dose #1  ____/____/________  b. Dose #2  ____/____/________  c. Dose #3  ____/____/________

I. PNEUMOCOCCAL POLYSACCHARIDE VACCINE
PCV 13 _______  Date  ____/____/________  PPSV 23 _______  Date  ____/____/________

J. MENINGOCOCCAL SEROUGROUP B
(Two or three dose series; may be given to any college student or for outbreak control; may be given with quadrivalent meningococcal vaccine at different anatomic site. Must complete series with the same vaccine.)
1. MenB-RC (Bexsero)  ____routine  ____outbreak –related
   a. Dose #1  ____/____/________  b. Dose #2  ____/____/________

OR
1. MenB-FHbp (Trumenba)  ____routine  ____outbreak-related
   a. Dose #1  ____/____/________  b. Dose #2  ____/____/________  c. Dose #3  ____/____/________

I. POLIO
(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)
1. OPV alone (oral Sabin three doses):  #1  ____/____/________  #2  ____/____/________  #3  ____/____/________

2. IPV/OPV sequential:     IPV #1  ____/____/________  IPV #2  ____/____/________  OPV #3  ____/____/________  OPV #4  ____/____/________

3. IPV alone (injected Salk four doses):  #1  ____/____/________  #2  ____/____/________  #3  ____/____/________  #4  ____/____/________
### M. TUBERCULOSIS (TB) SCREENING/TESTING

**Please answer the following questions:**

1. **Have you ever had close contact with persons known or suspected to have active TB disease?**
   - Yes
   - No

2. **Were you born in one of the countries or territories listed below that have a high incidence of active TB disease?**
   - Yes
   - No

### Please answer the following questions:

- Afghanistan
- Algeria
- Angola
- Antigua and Barbuda
- Argentina
- Armenia
- Azerbaijan
- Bangladesh
- Belarus
- Belize
- Benin
- Bhutan
- Bolivia (Plurinational State of)
- Bosnia and Herzegovina
- Botswana
- Brazil
- Brunei Darussalam
- Bulgaria
- Burkina Faso
- Burundi
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- China, Hong Kong SAR
- China, Macao SAR
- Colombia
- Comoros

**Source:** World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries and territories with incidence rates of ≥ 20 cases per 100,000 population. For further updates, refer to [http://www.who.int/tb/country/en/](http://www.who.int/tb/country/en/).

**Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease?**
   - 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,** [insert your college/university name] 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.**

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

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1The American College Health Association has published guidelines on “Tuberculosis Screening and Targeted Testing of College and University Students.” To obtain the guidelines, visit [http://www.acha.org/Guidelines](http://www.acha.org/Guidelines).
TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by health care provider)
Clinicians should review and verify the information above. Persons answering YES to any of the questions in Part M 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 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)

Date Obtained: ____/____/____  (specify method)  QFT-GIT  T-Spot  other____
Result: negative__  positive__  indeterminate__  borderline___ (T-Spot only)

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

Date of chest x-ray: ___/___/____ Result: normal____ abnormal____

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 jejunooileal 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

Name ___________________________ Signature ___________________________

Address ___________________________ Phone (_______) ________________________

END of FORM
### Personal History

**Have you had?**

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<thead>
<tr>
<th>Illness/Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Scarlet Fever</td>
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<tr>
<td>Chicken Pox</td>
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<td>Malaria</td>
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<td>Sinusitis</td>
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<td>Recurrent Colds</td>
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<td>Chronic Cough</td>
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<td>Dental Problems</td>
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<td>Eye trouble</td>
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<td>Ear, Nose, or Throat</td>
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<tr>
<td>Shortness of Breath</td>
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<td>Orthopedic Surgeries</td>
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<td>Surgery</td>
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<td>Hernia Repair</td>
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<td>Other:</td>
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**Other:**

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Insomnia</td>
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<td>Frequent Anxiety</td>
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<td>Worry or Nervousness</td>
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<td>Depression</td>
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<td>Recurrent Headache</td>
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<td>Head Injury</td>
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<td>Hay Fever, Asthma</td>
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<td>ADD/Hyperactivity</td>
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<tr>
<td>Disorder</td>
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<tr>
<td>Tuberculosis</td>
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<td>Allergy</td>
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<td>Penicillin</td>
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<td>Sulfonamides</td>
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<td>Serum</td>
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<td>Foods (which)</td>
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<tr>
<td>Other:</td>
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</table>

**Use additional sheet for remarks or additional information**

I understand that any special physical condition or circumstance that may arise may necessitate the infirmary personnel to share confidential information with local medical personnel to insure appropriate medical care.

**Student’s Signature**

**Physician’s Signature (acknowledging review)**

**Date**

---

### Family History

**Have any of your relatives ever had any of the following?**

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<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
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<td>Heart Disease</td>
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<tr>
<td>Arthritis</td>
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<tr>
<td>Stomach Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma, Hay Fever</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy, Convulsions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relationship**

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Galbladder trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Gallstones</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent Diarrhea</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recent Gain or Loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>of Weight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dizziness, Fainting</td>
<td></td>
<td></td>
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<tr>
<td>Weakness, Paralysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Albumin/Sugar in Urine</td>
<td></td>
<td></td>
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<tr>
<td>Frequent Urination</td>
<td></td>
<td></td>
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<tr>
<td>FEMALES ONLY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Currently Pregnant</td>
<td></td>
<td></td>
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<tr>
<td>Irregular Periods</td>
<td></td>
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<tr>
<td>Severe Cramps</td>
<td></td>
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<tr>
<td>Excessive Flow</td>
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</tbody>
</table>

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### Report of Medical History

**Please complete this before going to your physician for examination**

**Sex:** M ☐ F ☐

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### To the Student:

This information is strictly for the use of the Health Center and will not be revealed to anyone without your knowledge and consent.
TO THE HEALTH CARE PROVIDER: Please review the student’s history and complete the provider’s report. Please comment on all positive answers. This student has been accepted. The information supplied will not affect his/her status. It will be used only as a background for providing health and mental health care. Physical Exam must be done within 1 year prior to college entrance.

LAST NAME (Print) __________________________ FIRST NAME________________________ DOB:___/___/_____ SEX: M  F
BP___/___P ________ Height __________ Weight __________
VISUAL ACUITY: R _______/_______ L _______/_______ Corrected:  Y   N

Current Medications and Dosage: ________________________________________________

<table>
<thead>
<tr>
<th>Normal</th>
<th>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>
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<tr>
<td>Mouth, Nose, Throat</td>
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<tr>
<td>Neck</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
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<tr>
<td>Abdomen / Hernia</td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
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<tr>
<td>Metabolic/Endocrine</td>
<td></td>
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<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
</tr>
<tr>
<td>Emotional</td>
<td></td>
</tr>
</tbody>
</table>

- ☐ CLEARED for full activity ___________________________(list sport)
- ☐ CLEARED, with recommendation(s) for further evaluation or treatment for:
- ☐ NOT CLEARED for the following types of sports (please check those that apply):
  - ☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS
Is the patient currently under treatment for any medical or psychological condition? Yes _____ No _____
If yes, please explain:

______________________________

Do you have any recommendations regarding the care of this student, not previously addressed? Yes _____ No _____
If yes, please explain:

______________________________

Health Care Provider Signature __________________________ Health Care Provider Name (printed) __________________________
Address: _____________________________________________________
Provider Telephone Number: ______________________ Fax Number: ______________________ Date _____________
As a result of legislation enacted by the state legislature in July 2002, students living in campus housing are required to receive a vaccination for bacterial meningitis as a condition precedent to living on campus or sign a waiver in which they acknowledge that they understand the dangers relating to this potentially life threatening disease. Please call your health care provider immediately to receive this immunization. Proof of immunization must be provided to the Gable Health Center prior to admittance to campus housing.

- **What is meningococcal meningitis?** – Meningitis is a disease that can lead to swelling of the brain and spinal column and can cause permanent disabilities such as hearing loss, brain damage, seizures, limb amputation and even death.

- **How is it spread?** – Meningococcal meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

- **What are the symptoms?** – Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy, confusion and sensitivity to light.

- **Who is at risk?** – Young adults (15 to 24 years of age). College students have a greater risk of meningococcal infection than the general population because of activities that are often part of college life.

- **Can meningitis be prevented?** – Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. Adverse reactions to the meningitis vaccine are mild and infrequent, consisting primarily of redness and pain at the injection site and rarely a fever. As with any vaccine, vaccination against meningitis may not protect 100% of all susceptible individuals. The vaccine does not protect against viral meningitis.

**For more information** - To learn more about meningitis and the vaccine, visit the Gable Health Center or call (610) 921-7532. You may also visit the websites of the Centers for Disease Control and Prevention (CDC) at: [http://www.cdc.gov/meningitis/about/faq.html](http://www.cdc.gov/meningitis/about/faq.html) and the American College Health Association (ACHA) at [www.acha.org](http://www.acha.org). Your meningitis vaccination information must be provided to the Gable Health Center prior to your entrance into housing.
If you are declining vaccination due to medical or religious reasons please sign and date below and return to the Gable Health Center.

If you are unable to receive the meningococcal vaccine at your health care provider, please call the Gable Health Center at (610) 921-7532.

Thank you,
Joshua Williamson, M.D.
College Physician
Gable Health Center
Albright College

I understand that by signing this waiver, I am declaring that I have read and clearly understand the information about meningitis and the dangers relating to this disease and I have chosen to decline the meningitis vaccine at this time.

__________________________________________________
Print Name

__________________________________________________
Signature of Student Date

__________________________________________________
Social Security Number

__________________________________________________
Signature of Parent Date