January 2018

Dear Transfer Student:

Welcome to Gettysburg College! You must read and comply with the Gettysburg College health requirements in order to move on to campus, attend class, and participate in intercollegiate athletics. Medical information is kept confidential for use by the Health and Counseling Services.

You will need to accomplish two tasks to comply with the health requirements.

First, you will need to follow the dashboard directions and print copies of our physical exam form, immunization form and tuberculosis screening form. These must be taken to your health care provider to be filled out and returned to the Health Service by January 22, 2018 by mail or fax as shown above.

Second: You must fill out a health history on line, found on your dashboard page.

Please note the following:

- You must have or have had a complete physical exam by your home health care provider done after August 1, 2016 and returned to us by January 22, 2018. Athletes please note date below.
- Intercollegiate athletes' physicals must be done within six months of play – no sooner than August 1, 2017. Physicals done before that date will not satisfy NCAA regulations and will stop your ability to participate.
- Athletes and potential athletes please send us any medical records, testing reports, echocardiogram reports, clearances or specific releases to participate in sports from orthopedists, cardiologists or surgeons for cardiac conditions, chronic medical conditions, illnesses or injuries, especially orthopedic related, or any surgery you may have had. YOU WILL NOT BE ALLOWED TO TRY OUT OR PRACTICE WITHOUT THESE CLEARANCES.

Class registration and participation in intercollegiate sports will be in jeopardy until all medical information is complete, received and reviewed by the Student Health Service. Please do not return the physician forms until you have reviewed them and all the information requested is filled in. Do not depend upon your health care provider's office to return the forms for you. It is your responsibility.

Please note: The immunization record, which you will be printing out from the dashboard, is to be completed and signed by your health care provider. The immunization record must be current to meet our pre-matriculation immunization requirements.

The Student Health and Counseling Services welcomes you to our campus community. For further information about Health and Counseling Services, please visit the College website. You may also contact the Student Health Service at (717) 337-6970 or the Counseling Service for counseling/psychological questions or concerns at (717) 337-6960, Monday through Friday from 8:30am to 4:30pm.

Judith Williams, CRNP
Medical Director
Gettysburg College Health Service

Kathy Bradley, Ph.D.
Licensed Psychologist
Executive Director, Health & Counseling Center
Associate Dean of College Life
PHYSICAL EXAMINATION

TO THE EXAMINING PROVIDER: Please review the student’s history and complete this form. 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 care. This information is strictly for the use of the Health/Counseling Services and will not be released without student consent.

__________________________________________________________________________ Gender __________

Last Name (Print)  First Name  Middle

Athletes (recommended)

Height ______inches  Weight ______lbs  BMI ______  BP ______  Pulse______  Hct/Hgb__________

Ferritin__________

Acuity (Recommended)  with □ without □ correction  Right 20/____  Left 20/____

Baseline peak flow (if any Hx of Asthma) ____________________________

Urinalysis (Recommended)  Dipstick:  Glucose____  Blood____  Protein____  Bilirubin____

Ketones____  pH_____  Leukocytes____

Examiner please note any deviations from normal, innocent or not (i.e. innocent heart murmurs/ varicocele, etc.) Anything not noted and found later will be assumed to be a new problem.

This will be considered a pre-sport participation physical.

Are there any abnormalities of the following systems?

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<thead>
<tr>
<th>System</th>
<th>NO</th>
<th>YES</th>
<th>Describe fully</th>
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<tbody>
<tr>
<td>HEENT</td>
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<td>Respiratory</td>
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<td>Gastrointestinal</td>
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<td>Genitourinary (inc. hernia)</td>
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<td>Musculoskeletal</td>
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<td>Metabolic/Endocrine</td>
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<td>Neuropsychiatric</td>
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<tr>
<td>Skin</td>
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</table>

1. Is there loss or seriously impaired function of any organ?  Yes____  No____

2. Does student have physical appearance of Marfan’s syndrome?  Yes___  No____

3. Does the student plan on participating in an intercollegiate sport?  Yes___  No____

Which sport(s)? __________________________________________________________

4. On the basis of this examination, I find this student medically suitable to participate in intercollegiate sport activity at Gettysburg College.  Yes_____  No____

5. Do you have any recommendations regarding the care of this student?  Yes_____  No____

Explain: __________________________________________________________________

6. Is this patient now under treatment for any medical or emotional condition?  Yes_____  No____

Explain: __________________________________________________________________

Provider’s Signature__________________________ MD, DO, NP, PA

Return all information to:

Student Health Service
Gettysburg College
300 N. Washington St Box 436
Gettysburg, PA 17325 OR
Fax# 717-337-6978
IMMUNIZATION RECORD

Gettysburg College Health Service
300 N. Washington Street, Gettysburg, PA 17325 or Fax 717-337-6978

Student Last Name __________________________First Name____________________________ M______ DOB________________

Provider’s Name ______________________________Signature ______________________________Date____________________

Address_________________________________________________Phone______________________Fax____________________

IMMUNIZATION RECORD

IT IS IMPERATIVE THAT YOU RECEIVE AND HAVE RECORDS OF REQUIRED IMMUNIZATIONS PRIOR TO COMING TO GETTYSBURG COLLEGE. THERE WILL BE A CHARGE FOR ANY IMMUNIZATIONS RECEIVED AT THE STUDENT HEALTH SERVICE.

REQUIRED IMMUNIZATIONS OF ALL GETTYSBURG COLLEGE STUDENTS:

Completed childhood series:
Tetanus/Diphtheria/Pertussis (date completed)................................................................................_____/_____/____
   Booster (Please specify Tdap or Td) ................................................................................................._____/_____/____
   Polio series (date completed)....................................................................................................._____/_____/____

The following vaccines require official proof of vaccine (medical documentation) OR blood test showing immunity.

Measles, Mumps, Rubella (MMR) – 2 verified doses or titers demonstrating immunity.
Dose 1 given at age 12 months or later #1 _____/_____/____
Dose 2 given at least 28 days after dose 1    #2 _____/_____/____
   OR . . . Blood test confirming immunity (attach copy of lab result)

Varicella (Chicken Pox) – 2 verified doses or titers demonstrating immunity.
   #1 _____/_____/_____   #2 _____/_____/____
   OR . . . Blood test confirming immunity (attach copy of lab result)

Hepatitis B – 3 dose vaccine or titers demonstrating immunity
   #1 _____/_____/_____   #2 _____/_____/_____   #3 _____/_____/_____  
   OR . . . Blood test confirming immunity (attach copy of lab results)

Meningococcal – quadrivalent vaccine – 2 doses if first dose was given prior to age 16 – 1 dose if given after age 16
   #1 _____/_____/_____   #2 _____/_____/____

NOTE: Please read meningitis information on the Health Service web site under “FORMS/Health Information Links” regarding Pennsylvania law and the meningitis vaccination.

WAIVER: I have read and understand the information you provided about the risks of meningococcal disease and the availability and effectiveness of the vaccine, but for religious or other reasons, I decline the meningococcal vaccine at this time.

Signature (student)____________________________________________________________________Date____________________

Parent (if student under age 18)_________________________________________________________Date____________________

Highly recommended vaccines (please provide documentation of any vaccines that you have received)

Hepatitis A Vaccine – 2 doses  #1 _____/_____/_____   #2 _____/_____/_____ 

Human Papillomavirus Vaccine #1 _____/_____/_____   #2 _____/_____/_____   #3 _____/_____/_____ 

Meningitis B Vaccine  #1 _____/_____/_____   #2 _____/_____/_____   #3 _____/_____/_____/ (if Trumenba)
(See Meningitis B information on the Health Service web site under “FORMS/Health Information Links”)
Tuberculosis screening is required of all students entering Gettysburg College, based upon guidelines of the American College Health Association and the U.S. Centers for Disease Control. For more information, see www.acha.org or www.cdc.gov/tb.

(Student) Last Name__________________First_______________M______DOB_________________

Provider’s Name___________________________Signature_______________________Date______________

*IF THE ANSWER TO ALL THE QUESTIONS BELOW IS NO, NO FURTHER TESTING OR ACTION IS REQUIRED.

*IF THE ANSWER TO ANY OF THE QUESTIONS BELOW IS YES, the student must undergo Tuberculin Skin Testing, Quanti-Feron Tb testing, and/or chest x-ray as indicated, documented below:

1. Does the student have signs or symptoms of active tuberculosis disease? Y ( )  N ( )
   • Unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than three weeks.
   • Cough with production of bloody sputum (hemothysis)

2. Has the student ever had a positive Tuberculin Skin Test (TST, formerly PPD) or Quanti-Feron Tb Test  Y ( )  N ( )

3. Is the student a member of a high risk group?  Y ( )  N ( )
   • Had close contact with a known case of active tuberculosis
   • Use of illegal injected drugs
   • Currently on immunosuppressive therapy
   • Resident or employee of a nursing home, homeless shelter or correctional facility.

4. Has the student lived, traveled or had frequent or prolonged visits (more than 4 weeks) in the countries listed below where TB is endemic?  Y ( )  N ( )


   Tuberculin Skin Test : Date placed__________Date read_____________Results__________mm

   Quanti-FERON Test: Results: Positive ( )  Negative ( )

   Chest x-ray (required if current or previous TST or QFT test is positive):
   Date_________________________ Normal ( )  Abnormal ( )

   INH Treatment: Initiate Date_________________X__________________months  Declined ( )