MEDICAL HISTORY—Check all applicable items, whether current or past problem. Give details in the space provided below.

- Congenital Defects
- Heart defects
- Arthritis
- Mononucleosis
- Frequent sore throats
- Rheumatic fever
- Osteoporosis
- Treatment by psychologist, psychiatrist, or counselor
- Sinusitis
- Irritable bowel syndrome
- Urinary tract infections
- Menstrual disorder
- Frequent ear infections
- Ulcer disease
- Diabetes mellitus
- Skin disorder
- Hearing defects
- Inflammatory bowel disease
- Endocrine problem
- Smoker
- Serious eye defects
- Seizure disorder
- Drug problem
- Eating disorder
- Bronchitis
- Fainting
- Alcohol problem
- Concussion
- Asthma
- Seizure disorder
- Neurologic disorder
- Alcohol problem
- Concussion
- Pneumonia
- Headaches
- Learning disability/ADD
- Other

Details of above items checked:

________________________

Form in entirety reviewed by F&M Appel H.S. staff member: __________________________

Date: __________________________
FAMILY HISTORY

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Have any of your relatives ever had any of the following?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cancer: Yes/No, Relationship:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Diabetes: Yes/No, Relationship:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Heart Disease: Yes/No, Relationship:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Hypercholesterolemia: Yes/No, Relationship:</td>
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<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Hypertension: Yes/No, Relationship:</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Kidney Disease: Yes/No, Relationship:</td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td>Lung Disease: Yes/No, Relationship:</td>
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<td></td>
<td></td>
<td></td>
<td>Tuberculosis: Yes/No, Relationship:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ulcer Disease: Yes/No, Relationship:</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes: Father/Sister, No: Father/Mother, Relationship:</td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes: Father/Sister, No: Father/Mother, Relationship:</td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes: Father/Sister, No: Father/Mother, Relationship:</td>
</tr>
</tbody>
</table>

The above information is complete and accurate to the best of my knowledge.

STUDENT SIGNATURE ___________________________ DATE __________

PHYSICAL EXAMINATION (within one year of college entrance)

TO THE EXAMINING PRACTITIONER: Review the student's history and complete this report, the Tuberculosis Risk Assessment on page 3, and the Immunization Record on page 4.

BP:_________ Pulse:_________ Hgt:_________ Wgt:_________ BMI:_________

Date of physical exam _______/_______/_______

Baseline peak flow (if any Hx of Asthma) __________

Screening for Sickle Cell/Sickle Cell trait (NCAA required for ALL varsity athletics) Negative:______ Positive:______ Please attach lab results.

Are there abnormalities on examination of the following systems? Use additional sheet if needed. Please describe fully if abnormal.

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Ears, Eyes, Nose, Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Respiratory</td>
<td></td>
<td></td>
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<tr>
<td>3. Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Genitourinary (including hernia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Neurologic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Have you any general comments or recommendations regarding the care of this student? ____ No ____ Yes

2. Is the student now under treatment for any medical or emotional condition? ____ No ____ Yes

3. Please comment on any unresolved orthopedic injury, previous head or neck injury, heart murmur or irregular heart rate.

ARE THERE ANY RECOMMENDED RESTRICTIONS TO PARTICIPATION IN ATHLETIC OR EXTRACURRICULAR ACTIVITIES?

____ NO ____ YES EXPLAIN ________________________________
TUBERCULOSIS (TB) RISK ASSESSMENT—REQUIRED BY ALL STUDENTS

1. Have you ever had a positive tuberculosis skin test or blood test in the past? ................................................................. q Yes q No

2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)? ................................................................................................................................. q Yes q No

3. Were you born in a country NOT listed below?* ....................................................................................................................... q Yes q No

   If yes, did you arrive in the U.S. within the past 5 years? ........................................................................................................ q Yes q No

4. Have you traveled or lived for more than one month in any country NOT listed below?* .......................................................... q Yes q No

5. Have you ever had changes on a prior chest X-ray suggesting inactive or past TB disease? ....................................................... q Yes q No

6. Do you have a medical condition associated with increased risk of active TB if exposed: diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for>1 month), other immunosuppressive disorders, or are you an organ transplant recipient? ................................................................................................................................. q Yes q No

7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months? ......................................................................................................................... q Yes q No

8. Do you have a history of illicit drug use? ................................................................................................................................. q Yes q No

9. Have you ever received BCG vaccine? .........................................................................................................................................q Yes q No

** 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
- Immunosuppressed persons: taking >15 mg/d of prednisone for > 1 month; taking a TNF-α
- Persons with HIV/AIDS

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

The College reserves the right to require further testing for tuberculosis screening. International students who have returned to a high prevalence area during their first two years are expected to be rescreened during their third year. Students who study or travel in high prevalence areas should be screened for tuberculosis after their return. Screening tests for tuberculosis are available at Appel Health Services.

The American College Health Association has published guidelines on TB screening of college students that are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information visit www.acha.org/topics/tb.cfm or refer to CDC’s Q&A about TB at www.cdcnpin.org/scripts/tb/faq.asp#2
IMMUNIZATION RECORD

IMMUNIZATION RECORD (below) and TB RISK ASSESSMENT (page 3) TO BE COMPLETED BY YOUR HEALTH CARE PRACTITIONER WHO PERFORMS THE PHYSICAL (Dates must include month and year.)

IT IS IMPERATIVE THAT YOU RECEIVE OR HAVE RECORDS OF REQUIRED IMMUNIZATIONS PRIOR TO COMING TO F&M. THERE WILL BE A CHARGE FOR ANY IMMUNIZATIONS RECEIVED AT APPEL HEALTH SERVICES.

Required Immunizations:

A. **M.M.R. (Measles, Mumps, Rubella)** (Two doses required.)
   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. **Tetanus-Diphtheria** (primary series with DTaP, DTP, DT, or Td and booster with Td or Tdap in the last 10 years meets requirement.)
   1. Completed primary series (three doses if first dose ≥12 months of age) ....................... __/__/  
      M D Y  
      (four doses if first dose <12 months of age) .............................................................. __/__/  
      M D Y  
   2. Td booster within past 10 years .......................................................... #1 __/__/  
      M D Y  Tdap #2 __/__/  
      M D Y  
   3. A booster dose of Td may be given if 2 years since last Td to protect against pertussis ............ __/__/  
      M D Y  

C. **Polio** (Primary series in childhood meets requirement.)
   Completed primary series .............................................................................................. __/__/  
   M D Y  

D. **Hepatitis B**
   Dose #1 __/__/  Dose #2 __/__/  Dose #3 __/__/  
   M D Y  M D Y  M D Y  

   Hepatitis B Antibodies Yes / No (Please attach lab result.)

E. **Varicella** (chicken pox)
   Two doses of chicken pox vaccine at least one month apart #1 __/__/  #2 __/__/  
   M D Y  M D Y  
   OR blood test verifying immunity or medical documentation of disease (attach form)

F. **Meningococcal**
   Required by Pennsylvania state law for students who live in College owned housing. See enclosed information sheet and waiver below to sign if you choose not to be vaccinated.

   MENINGOCOCCAL MENINGITIS VACCINE*
   ❑ Menactra® Vaccine Dates #1 __/__/  #2 __/__/  
      (conjugate) M D Y  M D Y  
   ❑ Menevo® Vaccine Dates #1 __/__/  #2 __/__/  
      (conjugate) M D Y  M D Y  
   ❑ Menomune® Vaccine Dates #1 __/__/  #2 __/__/  
      (polysaccharide) M D Y  M D Y  

   *New CDC Recommendations (3/11)
   All adolescents and teens ages 11 through 18 years should be vaccinated with Menactra® or Menevo®, as should unvaccinated young adults 19 through 21 years who are attending college. Booster doses are recommended by CDC for those who got their dose before age 16 years.

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. (Parental signature required if under age 18.)

SIGNATURE OF STUDENT IF 18 OR OLDER DATE PARENT SIGNATURE IF STUDENT YOUNGER THAN 18 DATE

Recommended Immunizations:

A. **Hepatitis A**
   Dose #1 __/__/  Dose #2 __/__/  
   M D Y  M D Y  

   See website for www.acha.org/topics/vaccine.cfm

B. **Human Papillomavirus Vaccine**
   Dose #1 __/__/  
   M D Y  
   Dose #2 __/__/  
   Dose #3 __/__/  

See website for www.fandm.edu/healthservices

MD/NP/PA SIGNATURE ___________________________ DATE ____________
(Signature acknowledges review of history, verification of immunization record and tuberculosis screening, and performance of physical.)

ADDRESS ____________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

PRINT LAST NAME ___________________________  PHONE ___________________________
FAX ___________________________________________  

Return all information to:
DIRECTOR, APPEL HEALTH SERVICES
Franklin & Marshall College
P.O. Box 3003
Lancaster, PA 17604-3003
Phone: 717-291-4082
FAX: 717-291-4277
www.fandm.edu/healthservices