STUDENT MEDICAL FORM 2024-2025

Please contact Manor College Health Services with questions:
Phone: 215-885-2360 ext. 2241 | Fax: 215-572-0341
Email: healthservices@manor.edu

Please do not email completed health forms

Welcome Manor College student,

1. Fill out the student information on page 3 with name, starting semester, and permission to treat.
2. Have your physician complete the physical examination & vaccination history.
3. Residence Hall students must complete part 1 of TB screening (page 6) + physician to complete part 2 + 3 if indicated.

This form is REQUIRED for all Manor College athletes, residents, international students and specific programs. See below for more details.

COMMUTERS

1. Vaccine records including Tetanus x1 (within last 10 years), MMR series, Hepatitis B x3, and Varicella x2
   Possible booster shots may be required.

RESIDENT STUDENTS ARE ALSO REQUIRED TO HAVE:

1. Vaccine records including Tetanus x1 (within last 10 years), MMR series, Hepatitis B x3, and Varicella x2
2. Meningococcal tetravalent (mcv4—series of 2) + Meningococcal Group B (series of 2)
3. TB Questionnaire - completed by incoming students

VET TECH STUDENTS ARE ALSO REQUIRED TO:

1. Complete the enclosed Vet Tech Verification Form and follow all instructions given
2. Vaccine records including Tetanus x1 (within last 10 years), MMR series, Hepatitis B x3, and Varicella x2
3. Rabies Vaccination

DENTAL STUDENTS ARE ALSO REQUIRED TO HAVE:

1. PPD test results annually
2. Vaccine records including Tetanus x1 (within last 10 years), MMR series, Hepatitis B x3, and Varicella x2
3. Return original copy of this form to Dental

PRACTICAL NURSING STUDENTS ARE ALSO REQUIRED TO HAVE:

1. 2 step PPD or Quantiferon gold blood test within 3 months of starting the program
2. Vaccine records including MMR x2, Varicella x2, Hepatitis B series, Tdap (within last 10 years), Meningococcal tetravalent series (MCV4), Meningitis B series, Polio series and Covid 19

INTERNATIONAL STUDENTS MUST:

1. Vaccine records including Tetanus x1 (within last 10 years), MMR series, Hepatitis B x3, and Varicella x2
2. Submit proof of health insurance coverage valid in the United States

This form must be received prior to Aug. 15th for fall residence hall students and December 15th, for Spring residence hall students. All others must submit form prior to the start of classes.

Keep Original

Insurance: All students are encouraged to carry health insurance. Certain academic programs require health insurance. Student health insurance information is available through the Student Engagement Office. All those wishing to participate in Manor's Intercollegiate athletic programs must carry some form of health insurance prior to the start of the season's practice.
All international students must submit proof of health insurance coverage valid in the United States.

Immunization Policy: A medical form that includes immunization records must be completed and signed by a medical provider as well as the student or his/her parent. This form must be submitted upon admission to Manor College. Students will be unable to register for classes until the medical form is filled out. **Grades will be withheld until the completed form is filed with the Health Services Office. Be aware that certain immunizations are required for specific majors. Students are advised to follow the directions on the Medical Health Form or check with their program advisors. *Returning paper copy WILL NOT be accepted.**

Students seeking medical or religious exemptions MUST complete the Vaccine Exemption Request form and submit same to the Director.

Manor College Student Health Form
Health History Contact Sheet

Phone: 215-885-2360 ext. 2241 | Fax: 215-572-0341
Email: healthservices@manor.edu

Name: _____
Last *First* *Middle*

Program of Study: _____ Date of Birth: ____ /____/ ____ Gender: _____

College Entrance Date: (mo/yr): ____ / ____ Class (please circle): Fr So Jr Sr

Resident or Commuter? _____

Home Address: _____
Number and street *City* *State* *Zip*

Student's Cell Phone #: _____

Permission for Health Services to call via cell phone? Yes or No *Student Signature* _____

Please list up to 3 people whom we can contact in case of emergency: (in order of preference)

Name	*Relationship*	*Work Phone*	*CellPhone*
Name	*Relationship*	*Work Phone*	*CellPhone*
Name	*Relationship*	*Work Phone*	*CellPhone*

Permission to speak with guardian/parents about medical treatment? YES NO

Name of health insurance company: _____

Policy holder's name: _____ Group #: _____ Policy #: _____

Are you allergic to any medications/foods or have you had any bad reactions? YES NO If YES _____

List any medications you are currently taking with dosages:

_____

If you are 18 or older, please sign form yourself:
I grant permission to the college designee to hospitalize and/or secure treatment for me in the event of surgical, medical or psychiatric emergency if I am unconcious or incompetent at the time by virtue of accident or self-induced pathological process. I hereby certify that the information provided on this form is accurate, to the best of my knowledge.

Signature: _____ Date: _____

*If you are **UNDER** 18, parent/guardian must sign form.*
I grant permission to the college designee to hospitalize and/or secure treatment for my son/daughter/ward in the event of surgical, medical, or psychiatric emergency, provided the physician is unable to contact me reasonably soon and if in his/her professional judgement, further delay would jeopardize the patient's health or life. I hereby certify that the information provided on this form is accurate, to the best of my knowledge.

Signature: _____ Date: _____

Physical Examination

(Completed by examining provider) | Date of Physical _____ (Every two years encouraged)

Student's Name: _____

DOB: _____ Height: _____ Weight: _____ Allergies: _____ Restrictions: _____

The examinee **CAN / CANNOT** (circle one) participate in athletic activities. If not, please explain:

_____

Past Medical History

YES	NO	CONDITION	EXPLAIN	YES	NO	CONDITION	EXPLAIN
		Asthma, last attack				Bleeding disorders	
		Diabetes, last HbA1c				Fainting Spells	
		Hypertension				Bleeding disorders	
		Heart Disease (CHF, CAD, MI)				Thyroid Disease	
		Abdominal/Digestive problems				Stroke/TIA	
		Lung/Respiratory Disease				Sickle Cell Disease	
		Ear/Sinus problems				Seizure, last seizure	
		Muscular/skeletal condition				Sleep Disorder	
		Menstrual problems				Kidney Disease	
		Psychiatric/ psychological and emotional difficulties				Surgery	
		Behavioral disorders (e.g. ADD)				Serious Injury	

Provider's initial: _____ Date: _____

Physical Examination

	NORMAL	ABNORMAL	EXPLAIN ANY ABNORMALITIES		NORMAL	ABNORMAL	EXPLAIN ANY ABNORMALITIES
Head, Eyes, Ears, Nose, Throat				Musculo-skeletal			
Heart				Skin			
Lungs				Gastrointestinal			
Neurological | Psychiatric				Genitourinary			
Vascular							

Provider's Name: _____ MD, DO, PA, NP *(circle one)*

Provider's Signature: _____ Lic. #: _____ Phone #: _____

Varicella Titer
*must attach laboratory results

Manor College Required Immunizations for Students

Student Name: _____ Date of Birth: _____

1.	Tdap booster within last 10 years ** must have one documented	Mo. / day/ year	
2.	**Measles/Mumps/Rubella:** 2 doses of MMR at least 28 days apart after 12 months of age OR labratory proof of immunity (blood titer) to measles/ mumps/rubella. If titers are negative or equivocal, administer MMR series with doses at least 28 days apart. No titer is required after series completion.		
	MMR - 2 required on or after 1st birthday	(#1) Mo. / day/ year	(#2) Mo. / day/ year
	OR		
	MMR Titer *must attach laboratory results	Date of Titer	Result
	OR		
3.	**Varicella**: 2 doses of Varicella at least 4 weeks apart or laboratory proof of immunity to varicella. If titer is negative or equivocal, administer Varicella series with doses at least 4 weeks apart. No titer is required after series.		
	OR		
	Varicella Series 2 doses required	(#1) Mo. / day/ year	(#2) Mo. / day/ year
	Varicella Titer *must attach laboratory results	Date of Titer	Result
4.	**Hepatitis:** 3 doses of hepatitis B vaccines or a positive (> 10 mlU/mL) serological quantitative hepatitis B surface antibody titer (HBsAb) 1-2 months after the date of the last vaccine is considered proof of lifelong immunity .		
	Hepatitis B Series 3 doses required	(#1) Mo. / day/ year	(#2) Mo. / day/ year
	Hepatitis B titer *must attach laboratory results	Date of Titer	Result
5.	**Tuberculin Skin Test (TST):** Required for all dental students, all other students must complete TB screen questionnaire on page 6 and TB test information and/or lab results when indicated.		
	TST placed within the past 12 months	1st TST Place date	1st TST read date
	OR		
	IGRA TB Screening *must attach lab results* _____ T-Spot _____Quantiferon Gold	Date of IGRA	Result
6.	Meningococcal tetravalent (mcv4) 1 dose after 16th birthday	#1 mo/day/year	#2 mo/day/year
7.	Meningococcal Group B (Bexsero or Trumenba)	#1 mo/day/year	#2 mo/day/year

Health Care Provider's Signature: _____ Date: _____

Part I: Tuberculosis (TB) Screening Questionnaire

required for all boarding students

Student Name: _____ Date of Birth: _____

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? (If yes, please CIRCLE the country, below) ☐ Yes ☐ No

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.

3. 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? (If yes, CHECK the countries or territories, above) ☐ Yes ☐ No

4. 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

5. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

6. 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, Manor college requires that you receive TB testing as soon as possible but at least prior to the start of the subsequent semester. Please complete part II.

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.

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

Student Name: _____ Date of Birth: _____

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: ___/___/___ (M/D/Y) Date Read: ___/___/___ (M/D/Y)

Result: ____ mm of induration **Interpretation: positive negative

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ___/___/___ (M/D/Y) (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: ___/___/___ (M/D/Y) 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

_____ **Student agrees to receive treatment**

_____ **Student declines treatment at this time**

_____ _____

Health Care Professional Signature *Date*

Vaccine Exemption Request Form

All exemption requests must be accompanied by supporting documentation from a licensed medical professional or a member of your clergy/spiritual advisor

Full Name: _____ Date of Birth: _____ Manor ID: _____

I have been given a copy and have read, or have had explained to me, the Vaccine Information Statements (VIS) provided by the CDC. I understand the benefits and risks of the vaccine(s) required. (VIS can be found here: https://manor.edu/student-life/health-and-wellness/ and https://www.cdc.gov/vaccines/hcp/vis/current-vis.html)

Please indicate the vaccine(s) from which you are requesting an exemption:

- ☐ Hepatitis B (Series of 3)
- ☐ MMR Series
- ☐ Meningococcal Tetravalent* (mcv4-series of 2)
- ☐ Meningococcal Group B* (Series of 2)
- ☐ Rabies
- ☐ Tetanus/Tdap/DTap
- ☐ Varicella (Series of 2)
- ☐ Other: _____ (Additional vaccines may be required based on program or circumstance)

☐ Medical Exemption:

Physician /Provider Instructions: By completing this form and provide supporting documentation, you certify that any applicable vaccines have been considered and that the following medical contraindication precludes any/all vaccinations of the exempted type. You also certify that you provide regular health care for the patient above, are not a relative or personal/family friend, and the contraindication is documented in their medical records.

In the Provider's supporting documentation, please include the medically indicated contraindication for which you are requesting an exemption for the vaccine. (E.G. severe allergic reaction, immediate allergic reaction or known allergy to a component of the vaccine, and/or other medication circumstances preventing vaccination with any available vaccine.) Additionally, if it is an allergy, please describe the response in detail.

Name of Provider: _____ Provider's Address: _____

Provider's License No.: _____ Signature of Provider: _____ Date: _____

☐ Religious Exemption:

Religious Clergy/Spiritual Advisor Instructions: By completing this form and providing supporting documentation, you certify that the above named individual's religious beliefs prevent them from obtaining the selected vaccine. You also certify that you provide religious/spiritual services to the named individual above.

In your supporting documentation, please include the following information: State whether the religious belief prevents the named individual above from receiving a vaccination. If the religious belief prevents the named individual above from receiving only specific vaccines, please provide the reason why this is the case.

Name Clergy/Spiritual Advisor: _____ Phone Number: _____

Address of Clergy/Spiritual Advisor: _____

Signature of Clergy/Spiritual Advisor: _____ Date: _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature: _____ Date: _____

Signature of Parent/Guardian (if under 18): _____ Date: _____

* Per the College and University Student Vaccination Act (Senate Bill No. 955), students are allowed to request a philosophical exemption from the Meningococcal vaccine. Please submit a letter describing your philosophical exemption along with this form.

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