

Is the patient under the care of a medical specialist for any medical condition? Yes No

If yes, please explain: _____

Is the patient under treatment for any psychological condition? Yes No

Diagnosis: _____

Do you have any recommendations regarding the care of this patient? Yes No

Recommendations for physical activity/athletics: Unlimited Limited

Explanation: _____

Medications: (please list below) None

Allergies: (please list below) None Known

A complete immunization record must accompany this form. Please confirm that the student has received all required immunizations.

Physician's Signature: _____

Practice Name: _____

Practice Address: _____

Practice Phone Number / Fax Number: _____ / _____

REQUIRED Immunizations

Please attach documentation of the immunizations. Students will need to enter this data into the student health portal. Please note, if you require a second dose of any immunization, you will need to supply documentation of this dose to SHAW. If your doctor's office does not have this immunization, we suggest contacting your local Public Health Department or local pharmacy. International students whose countries do not provide certain immunizations will have an opportunity to schedule needed vaccines upon arrival. Requests for exemption can be sent to shaw@grinnell.edu.

Measles/Mumps/Rubella (MMR)

MMR is a 2 dose series. First dose must have been received **after** 12 months of age to qualify. Titers can be obtained as proof of immunity. NOTE: Laboratory results of titers must accompany this form.

Meningococcal Quadrivalent (A, C, W, Y)

Must be received at or after age 16 or a booster is required.

- Menactra
- Menveo
- Men ACWY

Serogroup Meningococcal B

Must receive 2 doses of the same brand. These brands are NOT interchangeable.

- Bexsero (2 dose series, 6 months between doses)
- Trumenba (2 dose series, 6 months between doses)

Tetanus, Diphtheria, Pertussis

Last dose must have been within 10 years.

- Td
- Tdap

Varicella

Varicella is a 2 dose series. First dose must have been **after** 12 months of age to qualify.

If you had the chicken pox disease, a physician **must** verify the date of disease (month/day/year) to eliminate the need for vaccination. ***Titers can be obtained as proof of immunity. NOTE: Laboratory results of titers must accompany this form.***

Tuberculosis Screening **See next page for details*

****Screening lab tests are not covered by insurance. Students are responsible for the cost of testing.***

RECOMMENDED Immunizations

- Hepatitis A Vaccine
- Hepatitis B Vaccine
- Human Papillomavirus (HPV) Vaccine
- Polio Vaccine
- COVID-19

Grinnell College **strongly** encourages all students to be fully vaccinated (including a booster dose)

Tuberculosis Screening

Please complete the **online** Tuberculosis Screening form.

As some students may be going to a physician before they complete the form, the questions are provided here.

If you answer yes to any of the below questions, you will need the Clinical Assessment Form (see next page).

1. Have you ever had a positive Tuberculin skin test (PPD)?
2. Have you had close contact with someone who was diagnosed with Tuberculosis?
Close contact is defined as having shared air space with an individual with Tuberculosis in an indoor setting for more than 15 hours per week.
3. Were you born in one of the countries listed below AND arrived in the U.S. within the past 5 years?
4. Have you traveled or lived for more than 1 month in one or more of the countries listed below? If yes, please check the country below.
5. Have you ever been vaccinated with BCG?
6. You have spent significant time (over 30 days??) in one of the below countries in the last 5 years.

World Health Organization (WHO): List of High-Risk Tuberculosis Exposure Countries

Angola	Kenya
Bangladesh	Lesotho
Brazil	Liberia
Central African Republic	Mozambique
China	Myanmar
Congo (Republic of the Congo)	Namibia
Democratic People's Republic of Korea (North Korea)	Nigeria
Democratic Republic of the Congo	Pakistan
Ethiopia	Papua New Guinea
Gabon	Philippines
Guinea	Sierra Leone
Guinea-Bissau	South Africa
Haiti	Tanzania (United Republic of)
India	Viet Nam
Indonesia	Zambia

Student Name: _____ Date of Birth: ____/____/____
Last First Middle M D Y

Clinical Tuberculosis Assessment by Health Care Provider

Persons answering YES to any of the questions on the Online Tuberculosis Screening Form are required to complete this form with their medical provider. Please write dates as Month, Day, Year.

1. 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) – Must be performed within six months of entrance to Grinnell College. TST result should be recorded as actual millimeters (mm) of induration (hard, dense, raised formation). If no induration, write “0”. **A test ≥ 10 mm of induration is considered positive.**

Date Test Placed: ____/____/____ **Date Test Read:** ____/____/____ **Result:** _____ mm of induration

3. Interferon Gamma Release Assay (IGRA) – **Only needed if positive TST results ≥ 10 mm of induration.** Testing must be performed within six months of entrance to Grinnell College.

The Quantiferon Gold blood test may be obtained in Grinnell. This blood test is not covered by insurance.

Date Obtained: ____/____/____ (Month, Day, Year)

Specify method: QFT-G QFT-GIT T-Spot other _____

IGRA Result: (The actual lab report is required and written or translated into English)

- Negative** **Positive – All positive IGRA results require a chest x-ray.**

Stand-alone chest x-ray will not satisfy TB requirement.

4. Chest x-ray: Required **if IGRA laboratory result is positive.**

Date of Chest x-ray: ____/____/____ (Month, Day, Year)

Result: **Normal** **Abnormal (seek immediate medical attention)**

All Chest X-Rays must be from the US and within the last 90 days.

5. Did the student receive treatment? Yes No

If yes, what medication regimen was prescribed?

Date treatment started:

____/____/____

Date treatment completed:

____/____/____

Physician's Signature: _____
 Practice Name: _____
 Practice Address: _____
 Practice Phone Number / Fax Number: _____ / _____
DATE OF EXAM: _____