Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Instructions for Healthcare Providers

The health information requested will not affect your patient's status at Bennington College, and will be kept confidential by Health Services staff. We value your assessment, and appreciate your assistance in assuring that your patient has met the following requirements by **January 15** (for spring term) or **July 15** (for fall term). We **must** have this information to legally allow your patient to register for classes or occupy student housing.

Health History (page 2)

Please review the health history with the patient.

Student Physical Examination (page 3)

Please conduct a physical examination with attention to the points requested. If you have conducted a complete physical examination within the past 12 months that includes, at a minimum, the points requested, you may provide a chart note as documentation instead of repeating the examination.

Immunization Record (page 4)

Please provide a record of the patient's immunizations. Required immunizations are indicated on the top half of the form. Please provide any missing required vaccines. If the patient does not have records, please offer to re-immunize or check immune titers and attach documentation of the results. Please sign and date at the bottom.

Tuberculosis Screening (page 5–6)

Tuberculosis screening form – Please review with the patient. If the patient is deemed to be at risk of tuberculosis exposure, as indicated by the April 2011 ACHA Guidelines, please conduct a tuberculin skin test and document the result.

Consent for Treatment (page 7)

This page is to be completed by the student and his/her parent/guardian.

Documentation of Varicella (Chickenpox) Disease (page 8)

If applicable, this page is to be completed by the student and his/her parent/guardian.

School Immunization Exemption Form (page 9)

If applicable, this page is to be completed by a Healthcare Provider and the student and/or his/her parent/guardian.

We recommend you photocopy all completed forms before mailing by **January 15** (for spring term) or **July 15** (for fall term) to Health Services, Bennington College, One College Drive, Bennington, Vermont 05201. You may also fax to 802-440-4427 or email to healthservices@bennington.edu.

continued on next page ▶

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Health History

Student's Name: _____ Date: _____
LAST FIRST MIDDLE NICKNAME

Cell Phone: _____ Bennington College Expected Graduation Date: _____

Date of Birth: _____ Sex: _____ Social Security #: _____

Home Address: _____

_____

Outpatient medical/psychiatric/psychological care: Date and diagnosis _____

_____

_____

Hospitalizations: List medical and psychiatric admissions.

Date: 1. _____ Reason: 1. _____

2. _____ 2. _____

3. _____ 3. _____

Medications: List those taken on a regular basis. Include dose and frequency.

_____

_____

_____

_____

Allergies: List allergies to medications or other agents.

☐ none

_____

_____

_____

Tobacco Use: _____ Alcohol: _____ Recreational Drugs: _____
PACKS PER DAY DRINKS PER WEEK WHAT TYPE

Personal and Family History:

RELATION	NAME	AGE	OCCUPATION	HEALTH STATUS
Mother:				
Father:				

Use the following identifiers to indicate if you or members of your family have the following problems:

1 (Personal) 2 (Mother) 3 (Father) 4 (Sister) 5 (Brother) 6 (Aunt) 7 (Uncle)
8 (Maternal Grandmother) 9 (Maternal Grandfather) 10 (Paternal Grandmother) 11 (Paternal Grandfather)

	Alcohol Abuse		Allergy		Asthma
	Bleeding Problem		Cancer		Developmental Disability
	Diabetes		Psychiatric/Psychological History		Genetic Disorder
	Heart Disease		High Blood Pressure		High Cholesterol
	Kidney Disease		Seizures		Ulcer
	Eating Disorder		Thyroid Problem		

continued on next page ▶

BENNINGTON COLLEGE

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Student Physical Examination

Student's Name: _____ Date of Birth: _____

Blood Pressure: _____ Pulse: _____ Height: _____ Weight: _____ BMI: _____

	NORMAL	ABNORMAL (explain)		NORMAL	ABNORMAL (explain)
General Appearance:	☐		Lungs:	☐	
Skin:	☐		Breasts:	☐	
Head:	☐		Abdomen:	☐	
Eyes:	☐		Genitourinary:	☐	
Nose:	☐		Extremities:	☐	
Mouth/Throat:	☐		Musculoskeletal:	☐	
Neck:	☐		Neurological:	☐	
Heart:	☐		Psychiatric:	☐	

Sexually Active: ☐ No ☐ Yes Birth control method: _____

Impressions: (List active problems.)	Treatment Plan:

Are there any limitations to physical activity (sports, dance, etc.)? _____

Explain, if any: _____

Healthcare Provider signature: _____ Date: _____

Please complete immunization records on next page, then sign form ▶

BENNINGTON COLLEGE

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Immunization Record

Student's Name: _____ Date of Birth: _____

REQUIRED VACCINES

Vaccines	Dates Given	Vermont State Requirements
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: _____/ _____/ _____/	2 doses **OR** positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday Option of combined MMR **OR** individual vaccines
Measles	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: _____/ _____/ _____/	
Mumps	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: _____/ _____/ _____/	
Rubella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Tdap or Td	**Tdap** _____ Td _____ #1 ___/___/___	1 Tdap/Td booster within last 10 years
Meningococcal	#1 ___/___/___ ☐ Menomune ☐ Menactra	One dose for first year students living in campus-based housing
Varicella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ OR History of disease: Date: _____/ _____/ _____/	2 doses varicella vaccine **OR** positive titer **OR** history of disease Minimum of 4 weeks between doses if age 13 or older Complete Documentation of Varicella (Chickenpox) Disease form
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___	3 doses **OR** positive titers Minimum 1 month between doses 1 and 2 Minimum 5 months between doses 2 and 3

RECOMMENDED / OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Hib	#1 ___/___/___	Primary series
Hepatitis A	#1 ___/___/___ #2 ___/___/___	Recommended if planning to travel Interval: 6–12 months between doses 1 and 2
Influenza	Most recent: ___/___/___	Recommended annually ___/___/___ ___/___/___
Pneumococcal	#1 ___/___/___ ☐ Polysaccharide (PPV) ☐ Conjugate (PCV)	Chronic health problems
Rabies	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Travel / occupational
Yellow Fever	#1 ___/___/___	Travel
Typhoid	☐ Oral ☐ Injectable	Travel
HPV	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Health care maintenance

SIGNATURE OF HEALTHCARE PROVIDER:

PRINT SIGNATURE DATE

ADDRESS PHONE FAX

continued on next page ▶

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Student's Name: _____ Date of Birth: _____

Tuberculosis (TB) Screening Questionnaire

Please answer the following questions:

Have you ever had a positive TB skin test?	☐ Yes	☐ No
Have you ever had close contact with anyone who was sick with TB?	☐ Yes	☐ No
Were you born in one of the countries listed below and arrived in the U.S. within the past five years? (If yes, please CIRCLE the country below.)	☐ Yes	☐ No
Have you ever traveled* to/in one or more of the countries listed below? (If yes, please CHECK the country/ies below.)	☐ Yes	☐ No
Have you ever been vaccinated with BCG?	☐ Yes	☐ No

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

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Saint Vincent and the Grenadines
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
The former Yugoslav Republic of Macedonia
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2009. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to **http://apps.who.int/ghodata/?vid=510**.

If the answer is YES to any of the above questions, Bennington College requires that a healthcare provider complete the tuberculosis risk assessment on page 6 (to be completed within six months prior to the start of classes).

If the answer to all of the above questions is NO, no further testing or further action is required.

The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers of Disease Control and the American Thoracic Society. For more information, visit acha.org.

Prepared originally by ACHA's Tuberculosis Guidelines Task Force

continued on next page ▶

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Tuberculosis (TB) Risk Assessment

Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

Risk Factor		
Recent close contact with someone with infectious TB disease	☐ Yes	☐ No
Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	☐ Yes	☐ No
Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Organ transplant recipient	☐ Yes	☐ No
Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF- antagonist)	☐ Yes	☐ No
History of illicit drug use	☐ Yes	☐ No
Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other healthcare facilities)	☐ Yes	☐ No
Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)	☐ Yes	☐ No

---

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

1. Does the student have signs or symptoms of active tuberculosis disease? ☐ **Yes** ☐ **No**

If NO, proceed to 2 or 3. If YES, 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: ____/____/____

Result: _____ mm of induration **Interpretation: ☐ positive ☐ negative

3. Interferon Gamma Release Assay (IGRA)

Date Obtained: ____/____/____ (PLEASE CIRCLE method) QFT-G 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: ____/____/____ Result: ☐ normal ☐ abnormal

**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 antagonist
- Persons with HIV/AIDS

>10 mm is positive:
- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker, or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:
- Persons with no known risk factors for TB disease

*The significance of the exposure should be discussed with a healthcare provider and evaluated.

continued on next page ▶

Health Services • One College Drive • Bennington, Vermont 05201 • www.bennington.edu

Consent for Medical Treatment

Student under age of 18: Consent of Custodial Parent or Legal Guardian

In the event that _____ (PLEASE PRINT STUDENT'S NAME) requires **non-emergency medical treatment** while under the age of 18, I, being a custodial parent or legal guardian of the named student, with full legal authority to consent to medical treatment, consent to such treatment of my child or ward without further consultation or consent prior to providing treatment.

In the case of **emergency medical treatment** while under the age of 18, I understand that an attempt will be made by the College to contact me at _____ (CONTACT INFORMATION) to obtain consent for treatment. However, if emergency medical treatment is necessary in my child or ward's treating health care professional's opinion prior to contacting me, this authorizes emergency medical treatment.

Parent or Guardian's Signature: _____ Date: _____

Student 18 years of age or older: Consent of Student for Emergency Care

In the event that I, _____ (PLEASE PRINT STUDENT'S NAME) require **non-emergency medical treatment** and am not competent to give consent at that time, I understand that an attempt will be made to contact _____ (NAME OF PARENT OR OTHER DESIGNATED PERSON; SPECIFY RELATIONSHIP TO STUDENT) whose contact information is _____ (CONTACT INFORMATION), and I authorize that person to consent to such emergency treatment in my stead. However, if emergency medical treatment is necessary in my treating health care professional's opinion prior to contacting the person named above, this authorizes emergency medical treatment.

Student's Signature: _____ Date: _____

The student is covered by medical insurance as follows:

Company: _____

Company Address and Phone Number: _____

Policy Holder's Name and Date of Birth: _____ (PLEASE PRINT)

Group Number: _____ ID Number: _____

Is pre-authorization required by your health insurance? ☐ Yes ☐ No

Pre-authorization Phone: _____

Are medications covered? ☐ Yes ☐ No Pharmaceutical Benefits Phone: _____

Documentation of Varicella (Chickenpox) Disease

VERMONT
DEPARTMENT OF HEALTH

Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider.

This document is being submitted on behalf of the following student:

Name:

_____ _____
Last First

Date of Birth :

____/____/_____

I _____ **verify that the above listed student**
Parent/Guardian/Self (18 and over)

had varicella (chickenpox) disease in _____/_____.
Month Year

_____ _____/_____/_____
Signature of parent or guardian of student or student 18 and over Date

The Vermont Department of Health
Immunization Program
108 Cherry Street
Burlington, Vermont 05401

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov

School Immunization Exemption Form

VERMONT
DEPARTMENT OF HEALTH

Vermont's School Immunization Regulations apply to any students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations unless exempt for medical, religious, or moral (philosophic) reasons. In order to claim an exemption this form needs to be completed, signed and returned to the school.

Please note that students who claim an exemption may be kept out of school during the course of a disease outbreak. The reason for this is that such students will be at high risk for getting that disease and in-turn transmitting it to other students. The length of time a student is kept out of school will vary depending on the type of disease and the circumstances surrounding the outbreak. This may be from as little as several days to over a month.

This document is being submitted on behalf of the following student:

Name: _____ _____ **Date of Birth:** ____/____/____

Last **First**

☐ MEDICAL EXEMPTION

The following vaccine(s) are medically contraindicated:

☐ **DTaP/DTP** ☐ **Td/Tdap** ☐ **Polio** ☐ **Hepatitis B** ☐ **Varicella**

☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Meningococcal**

Reason for exemption(s): _____

This exemption shall continue until : ____/____/_____

_____ (____)_____

Print Name of Physician **Telephone**

_____ ____/____/_____

Signature of Physician **Date**

☐ MORAL (PHILOSOPHIC) EXEMPTION ☐ RELIGIOUS EXEMPTION

I request that following immunization(s) be waived because they conflict with free exercise of religious rights and /or moral (philosophic) rights:

☐ **DTaP/DTP** ☐ **Td/Tdap** ☐ **Polio** ☐ **Hepatitis B** ☐ **Varicella**

☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Meningococcal**

_____ (____)_____ ____/____/_____

Signature of Parent (or student if 18 yrs or older) **Telephone** **Date**

The Vermont Department of Health
Immunization Program
108 Cherry Street
Burlington, Vermont 05401

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov