Wheaton College Student Health Services

MEDICAL SCREENING FORM — Completed by Student

Name_____ Student ID#_____
Last First Middle Initial (assigned by school)

Date of Birth_____ Sex M F

Date of enrollment: ☐ Fall_____(year) ☐ Spring_____(year) ☐ Summer_____(year)

Home Address_____Cell phone _____
Street City State Zip

Person to be notified in emergency **in U.S.**_____ Relationship _____

U.S. Phone Number of Emergency Contact _____

All students who are taking **six or more credit hours** on campus at least one semester during the entire course of their study must show proof of immunity by returning this completed form **BEFORE ENROLLMENT**. Students born before Jan 1, 1957 are exempt from MMR, may write "AGE" in measles, mumps, and rubella boxes. Attach vaccine records, if available.

IMMUNIZATION CERTIFICATE — Completed by Provider

To Comply with Illinois Law all dates MUST include Month, Day &Year; Official print-out of records also accepted

Required Immunization	Date of Vaccine	Date of Vaccine	Alternate
MEASLES (Rubeola): 2 doses of measles vaccine are required on or after first birthdate AND after January 1, 1968. The second dose should be given no sooner than 28 days after the first dose.	**1**	**2**	Immunity confirmed by blood test (attach copy of lab report) Date:
MUMPS: 2 doses of mumps virus vaccine required on or after first birthdate. The second dose must be given no sooner than 28 days after the first dose.	**1**	**2**	Immunity confirmed by blood test (attach copy of lab report) Date:
RUBELLA (German Measles): 2 doses of rubella vaccine are required on or after first birthdate. The second dose must be given no sooner than 28 days after the first dose.	**1**	**2**	Immunity confirmed by blood test (attach copy of lab report) Date:
TETANUS/DIPHTHERIA/PERTUSSIS: 3 required doses. One dose must be Tdap, the most recent dose must be received within 10 years prior to term of current enrollment. At least six months required between 2nd and 3rd dose.	**1**	**2**	Tdap: **3**
MENINGOCOCCAL (Meningitis): Required for students under age 22 at start of fall semester, must have been **after** 16th birthday.	**1**		
If medical or religious exemption needed for any of the above vaccines, request Immunization Waiver document from SHS			

Providers licensed to practice medicine in all of its branches (MD, DO, NP or PA) or Registered Nurse or a Public Health Official must verify above information with their signature below.

Healthcare provider name (print) _____ Signature _____

Wheaton College Student Health Services

MEDICAL SCREENING FORM — Completed by Student

This information is strictly confidential and will be used as an aid in providing necessary health care while you are a student. It will not be released to anyone without your written consent.

Student ID # _____

Name_____ Sex ☐ M ☐ F Date of Birth_____

Last First Middle

PERSONAL HEALTH SCREENING

Do you have any condition that requires accommodation while at Wheaton College, such as an allergy or disability? Please describe.

_____

_____

Do you have a serious condition or illness which requires ongoing medical treatment? Please describe.

_____

_____

Do you have allergies (indicate reactions):

Drugs (specify) _____

Foods (specify) _____

Do you take medicine regularly? ☐ Yes ☐ No

If yes, specify and give reason _____

_____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

SHS will review this form and contact you if you need an individual plan for further testing. Testing may include a PPD skin test(s) or an IGRA blood test. These services may be available through Student Health Services.

If *yes* to the any of the following, please describe:	**Explanation**
1. Have you ever been told by a doctor or healthcare provider that you had active TB?	□ **Y** □ **N**
2. Have you ever taken medication for TB? Which medication(s)? What year?	□ **Y** □ **N**
3. Have you ever had a BCG vaccine for TB? (BCG does not exempt you from this requirement)	□ **Y** □ **N**
4. Have you ever been told by a health care provider that your immune system is not working right or that you cannot fight infection? (e.g. immune disorder or illness)	□ **Y** □ **N**
5. Have you cared for, or lived with, anyone diagnosed with active TB disease in the past year?	□ **Y** □ **N**
6. Have you worked or volunteered in a setting where TB may be more common, such as a homeless shelter, nursing home, group home, or prison, in the past year?	□ **Y** □ **N**
7. Have you travelled outside the USA in the past year? If yes, please answer # 8	□ **Y** □ **N**
8. Where:	Length of stay: Date of return:
9. In what country were you born?_____	In USA since what year? _____
10. Have you received a live vaccine in the past 6 weeks? (e.g. measles, mumps, rubella, chickenpox, or shingles)	□ **Y** □ **N**

Have you experienced any of the following symptoms?	**Y**	**N**	**Have you experienced any of the following symptoms?**	**Y**	**N**
Persistent coughing (3 weeks or more)			Unexplained weight loss?		
Coughing up blood or bloody mucous			Unexplained, excessive fatigue?		
Night sweats (soak the sheets)			Fever of unknown origin?		

Submit through your MyChart or send completed form to
Wheaton College Student Health Services,
501 College Ave, Wheaton, IL 60187
Or fax to 630-752-5575

Signature (student)_____ Date_____