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 Attended grades 9-12 in U.S.? ☐ Yes ☐ No

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

I have resided or visited outside the U.S. ☐ Yes ☐ No

Home Address_____ Telephone _____
Street City State Zip

Person to be notified in emergency_____ Relationship _____

Home Telephone Number_____ Cell Telephone Number _____

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

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.

Health Care 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 Age_____ 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:

Drugs (specify)_____

Foods (specify) _____

Animals (specify)_____

Other (specify)_____

Do you take medicine regularly? ☐ Yes ☐ No

If yes, specify and give reason _____

_____

Wear glasses, hearing aid, retainer or braces, prosthesis?

If yes, specify _____

TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE

SHS will review this form and reply to your my.wheaton email account if you need an individual plan for further testing or treatment. Treatment may include a PPD skin test(s) or an IGRA blood test. Depending on your individual plan, 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, fax to 630-752-5575, or send completed form to Wheaton College Student Health Services, 501 College Ave, Wheaton, IL 60187

Signature (student)_____ Date_____