PHYSICAL EXAMINATION (Must be within one year of July 1 for Fall admission, January 13 for Spring admission, within six months of enrollment for NCAA athletics. Cannot be completed by parent clinician.)

STUDENT'S NAME: DOB: (MM/DD/YY) DATE OF EXAMINATION: (MM/DD/YY)

HEIGHT: WEIGHT: BMI: BLOOD PRESSURE: PULSE:

LABORATORY REPORTS REQUIRED for INTERCOLLEGIATE ATHLETES ONLY
(Students will be required to have below lab testing during orientation if reports are not submitted. Fees will apply):

❑ SICKLE CELL SCREEN
Please provide copies of additional lab reports if applicable: evidence of immunity to an illness or disease, TB IGRA, cholesterol, endocrine or specialty labs, etc.

VISION: RIGHT LEFT

UNCORRECTED 20/ 20/

CORRECTED 20/ 20/

CONTACT LENS ❑ YES ❑ NO

PRESCRIPTION:

	NORMAL	ABNORMAL DESCRIBE ABNORMALITIES
SKIN, LYMPH NODES	❑	❑
HEAD, NOSE, SINUSES	❑	❑
MOUTH, TEETH, GINGIVA	❑	❑
EARS (CANALS, DRUMS)	❑	❑
HEARING	❑	❑
EYES (SEE ABOVE)	❑	❑
THROAT, THYROID	❑	❑
LUNGS, CHEST	❑	❑
HEART	❑	❑
BREASTS	❑	❑
BACK	❑	❑
ABDOMEN	❑	❑
PELVIC (IF INDICATED)	❑	❑
EXTREMITIES, JOINTS	❑	❑
NEURO	❑	❑

LIST ALL CURRENT MEDICATIONS:

LIST ALL KNOWN ALLERGIES: (INCLUDE MEDICATIONS, FOOD, SUBSTANCE)

Please describe any significant illnesses, injuries, or hospitalizations in this patient's past history. Please comment on any physical or emotional problems that the health service should be aware of regarding this patient, including past history, medications, and current treatments. Provide copies of clinical records for continuity of care.

❑ **PLEASE CHECK IF THE STUDENT INTENDS TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS.** **PLEASE INDICATE TEAM**

Intercollegiate Athletes only - PE required within 6 months of enrollment. Attach required copy of sickle cell screening lab report.

RECOMMENDATION FOR PHYSICAL EDUCATION AND ACTIVITY:

UNLIMITED ❑ LIMITED ❑ EXPLAIN:

CLINICIAN'S NAME *(Not parent clinician)* CLINICIAN'S SIGNATURE (M.D., N.P., PA) TODAY'S DATE

ADDRESS TELEPHONE NO. FAX NO.

Step 1

TUBERCULOSIS SCREENING QUESTIONNAIRE

For completion by <u>all students.</u>

STUDENT'S NAME: DOB: (MM/DD/YY)

	YES	NO
1. Have you ever had a positive TB skin test?	❑	❑
2. Have you ever had close contact with anyone who was sick with TB?	❑	❑
3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * (If yes, please CIRCLE the country)	❑	❑
4. Have you ever traveled** to/in one or more of the countries listed below? (If yes, please CIRCLE the country/ies)	❑	❑
5. Have you ever been vaccinated with BCG?	❑	❑

* Future CDC updates may eliminate the 5 year time frame.
** The significance of the travel exposure should be discussed with a health care provider and evaluated.

AFGHANISTAN
ALBANIA
ALGERIA
AMERICAN SAMOA
ANDORRA
ANGOLA
ANGUILLA
ANTIGUA AND BARBUDA
ARGENTINA
ARMENIA
ARUBA
AUSTRALIA
AUSTRIA
AZERBAIJAN
BAHAMAS
BAHRAIN
BANGLADESH
BARBADOS
BELARUS
BELGIUM
BELIZE
BENIN
BERMUDA
BHUTAN
BOLIVIA (PLURINATIONAL STATE OF)
BONAIRE, SAINT EUSTATIUS AND SABA
BOSNIA AND HERZEGOVINA
BOTSWANA
BRAZIL
BRITISH VIRGIN ISLANDS
BRUNEI DARUSSALAM
BULGARIA
BURKINA FASO
BURUNDI
CAMBODIA
CAMEROON
CANADA
CAPE VERDE
CAYMAN ISLANDS
CENTRAL AFRICAN REPUBLIC
CHAD
CHILE
CHINA
CHINA, HONG KONG SAR
CHINA, MACAO SAR
COLOMBIA
COMOROS
CONGO
COOK ISLANDS
COSTA RICA
CÁ´TE D'IVOIRE
CROATIA
CUBA
CURAÃ§AO
CYPRUS
CZECH REPUBLIC
DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA
DEMOCRATIC REPUBLIC OF THE CONGO
DENMARK
DJIBOUTI
DOMINICA
DOMINICAN REPUBLIC
ECUADOR
EGYPT
EL SALVADOR
EQUATORIAL GUINEA
ERITREA
ESTONIA
ETHIOPIA
FIJI
FINLAND
FRANCE
FRENCH POLYNESIA
GABON
GAMBIA
GEORGIA
GERMANY
GHANA
GREECE
GREENLAND
GRENADA
GUAM
GUATEMALA
GUINEA
GUINEA-BISSAU
GUYANA
HAITI
HONDURAS
HUNGARY
ICELAND
INDIA
INDONESIA
IRAN (ISLAMIC REPUBLIC OF)
IRAQ
IRELAND
ISRAEL
ITALY
JAMAICA
JAPAN
JORDAN
KAZAKHSTAN
KENYA
KIRIBATI
KUWAIT
KYRGYZSTAN
LAO PEOPLE'S DEMOCRATIC REPUBLIC
LATVIA
LEBANON
LESOTHO
LIBERIA
LIBYA
LITHUANIA
LUXEMBOURG
MADAGASCAR
MALAWI
MALAYSIA
MALDIVES
MALI
MALTA
MARSHALL ISLANDS
MAURITANIA
MAURITIUS
MEXICO
MICRONESIA (FEDERATED STATES OF)
MONACO
MONGOLIA
MONTENEGRO
MONTSERRAT
MOROCCO
MOZAMBIQUE
MYANMAR
NAMIBIA
NAURU
NEPAL
NETHERLANDS
NEW CALEDONIA
NEW ZEALAND
NICARAGUA
NIGER
NIGERIA
NIUE
NORTHERN MARIANA ISLANDS
NORWAY
OMAN
PAKISTAN
PALAU
PANAMA
PAPUA NEW GUINEA
PARAGUAY
PERU
PHILIPPINES
POLAND
PORTUGAL
PUERTO RICO
QATAR
REPUBLIC OF KOREA
REPUBLIC OF MOLDOVA
ROMANIA
RUSSIAN FEDERATION
RWANDA
SAINT KITTS AND NEVIS
SAINT LUCIA
SAINT VINCENT AND THE GRENADINES
SAMOA
SAN MARINO
SAO TOME AND PRINCIPE
SAUDI ARABIA
SENEGAL
SERBIA
SEYCHELLES
SIERRA LEONE
SINGAPORE
SINT MAARTEN (DUTCH PART)
SLOVAKIA
SLOVENIA
SOLOMON ISLANDS
SOMALIA
SOUTH AFRICA
SOUTH SUDAN
SPAIN
SRI LANKA
SUDAN
SURINAME
SWAZILAND
SWEDEN
SWITZERLAND
SYRIAN ARAB REPUBLIC
TAJIKISTAN
THAILAND
THE FORMER YUGOSLAV REPUBLIC OF MACEDONIA
TIMOR-LESTE
TOGO
TOKELAU
TONGA
TRINIDAD AND TOBAGO
TUNISIA
TURKEY
TURKMENISTAN
TURKS AND CAICOS ISLANDS
TUVALU
UGANDA
UKRAINE
UNITED ARAB EMIRATES
UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND
UNITED REPUBLIC OF TANZANIA
URUGUAY
UZBEKISTAN
VANUATU
VENEZUELA (BOLIVARIAN REPUBLIC OF)
VIET NAM
WALLIS AND FUTUNA ISLANDS
WEST BANK AND GAZA STRIP
YEMEN
ZAMBIA
ZIMBABWE

If the answer is YES to any of the above questions, Wellesley College requires that a health care provider complete a tuberculosis risk assessment (to be completed within one year of enrollment). Please complete Step 2, found on page 3.

If the answer to all of the above questions is NO, no further testing or further action is required. Clinician sign page 4.

WORLD HEALTH ORGANIZATION. GLOBAL TUBERCULOSIS CONTROL. WHO REPORT 2011.

Step 2

TUBERCULOSIS RISK ASSESSMENT

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

Required if yes answer to any Tuberculosis screening questions.

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:

	YES	NO
1. Recent close contact with someone with infectious TB disease	❑	❑
2. Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	❑	❑
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	❑	❑
4. HIV/AIDS	❑	❑
5. Organ transplant recipient	❑	❑
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-antagonist)	❑	❑
7. History of illicit drug use	❑	❑
8. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	❑	❑
9. 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)]	❑	❑
10. Does the student have signs or symptoms of active tuberculosis disease?	❑	❑

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

If all above answers are no, clinician sign page 4. If any question is answered yes, proceed to step 3 with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

Step 3

TUBERCULOSIS RISK ASSESSMENT

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

Option 1 Tuberculin Skin Test (TST) - within 1 year of July 1 for Fall admission January 13 for Spring admission

*TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if noinduration, 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 ❑

DATE GIVEN: ____M____/____D____/____Y____ DATE READ: ____M____/____D____/____Y____

RESULT: _____ MM OF INDURATION **INTERPRETATION: POSITIVE ❑ NEGATIVE ❑

Option 2 Interferon Gamma Release Assay (IGRA)

DATE OBTAINED:____M____/____D____/____Y____(SPECIFY METHOD) QFT-G QFT-GIT OTHER_____

RESULT: NEGATIVE ❑ POSITIVE ❑ INTERMEDIATE ❑

DATE OBTAINED:____M____/____D____/____Y____(SPECIFY METHOD) QFT-G QFT-GIT OTHER_____

RESULT: NEGATIVE ❑ POSITIVE ❑ INTERMEDIATE ❑

Step 4 Chest x-ray: (Required if TST or IGRA is positive)

DATE OF CHEST X-RAY: ____M____/____D____/____Y____ RESULT: NORMAL_____ ABNORMAL_____

Dates of treatment for LTBI: _____

medication and dose _____

_____

CLINICIAN'S SIGNATURE DATE

_____

CLINICIAN'S PRINTED NAME

TST **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- 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