Health Center • 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 Center staff. We value your assessment, and appreciate your assistance in assuring that your patient has met the following requirements by **January 15** (for undergraduate spring term), or **May 15** (for postbac students), or **July 1** (for undergraduate 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 their parent/guardian.

Proof of Insurance (page 8)

This page is to be completed by the student and their parent/guardian. If more time is needed to secure insurance, this page can be separately submitted later than July 1. Please submit Proof of Insurance no later than August 15.

Documentation of Varicella (Chickenpox) Disease (page 9)

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

School Immunization Exemption Form (page 10)

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

We recommend you photocopy all completed forms before mailing by **January 15** (for undergraduate spring term), or **May 15** (for postbac students), or **July 1** (for undergraduate fall term) to Health Center, 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 ▶

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Health History

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

Sex: _____ Gender Identity: _____ Pronouns: _____

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 ▶

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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: _____

SIGNATURE OF HEALTHCARE PROVIDER:

PRINT SIGNATURE DATE

ADDRESS PHONE FAX

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

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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 First dose given after first 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 ___/___/___ #2 ___/___/___	A second dose is required if first dose given before age 16
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

HEALTHCARE PROVIDER SIGNATURE DATE

☐ CHECK BOX IF SEPARATE RECORDS ATTACHED

continued on next page ▶

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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

Afghanistan
Algeria
Angola
Argentina
Armenia
Azerbaijan
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
Côte d'Ivoire
Democratic People's Republic of Korea Democratic Republic of the Congo Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
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
Mexico
Micronesia (Federated States of)
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
South Sudan
Suriname
Swaziland
Syrian Arab Republic
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

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

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015. 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 ▶

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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 ▶

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: _____

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Proof of Health Insurance

All full-time Bennington College students are required to be covered by a health insurance policy and to provide proof of coverage to the Health Center. If more time is needed to secure insurance, this page can be separately submitted later than July 1. Please submit Proof of Insurance no later than August 15. You are required to resubmit this form anytime you have change to your insurance policy.
When resubmitting, email to: healthservices@bennington.edu.

If you have coverage through both parents, please supply information on both policies and indicate which one is primary.

Student Name:_____ Date of Birth:_____

Name of Policy Holder:_____

Policy Holder Date of Birth:_____ Relationship to Student:_____

Health Insurance Company:_____

☐ Include copy of insurance card front and back. If Medicaid based policy, please check here ☐

Health Insurance Company Address:_____

Health Insurance Company Phone Number:_____

Policy Number:_____ Group Number:_____

Coverage Effective Date:_____ End Date:_____

Student Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Patient Billing, Consent, and Assignment

Billing Address (Where do you want the bill sent?): _____

Responsible party if other than student:_____

Mailing Address:_____

City:_____ State & Zip:_____

Phone:_____ Relationship to Student:_____

I authorize Bennington College to file insurance claims on my behalf to the company(ies) with which I have coverage as provided on the Proof of Insurance form. I also permit the release of protected medical or other information about me, which may be required for filing such claims, to the physician's billing company and to my insurance company(ies). I have a right to be notified following a breach of my unsecured PHI. I understand that I have the right to restrict certain disclosures of PHI to a health plan when I pay for treatment at issue out of pocket in full. I permit a copy of this authorization to be used in placed of the original.

I request that payment under the medical insurance program(s) be made to Bennington College for services rendered to me. I understand that I am responsible for any amount not covered by my insurance.

I understand that I have the right to revoke this consent in writing, except to the extent of action taken in reliance of this consent.

Patient Signature:_____ Date:_____

continued on next page ▶

VERMONT
DEPARTMENT OF HEALTH

Documentation of Varicella (Chickenpox) Disease

Vermont's Immunization Rule applies to any child or student attending any center-based or family child care facility, public or independent kindergarten, elementary and secondary schools, and undergraduates enrolled in colleges and universities. Before entry, children/students must have the required immunizations unless exempt for medical or religious reasons.

Before entry, all vaccine requirements must have been met, including two doses of varicella (chickenpox) vaccine. However, for those with a history of chickenpox disease, neither a vaccine nor an exemption is needed. This form (or other documentation such as a signed statement, or notation in an Immunization Registry or other health record) may be submitted to the child care program, school or college in lieu of vaccination. The signature of a health care practioner is not needed.

Complete all information below on behalf of the child/student named. This form may not be altered.

_____ ____/____/____
Child/Student first and last name Date of birth

I _____ verify that the above listed student had
Parent/Guardian/Self (if age 18 or older)

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

_____ _____/_____/____
Signature of parent or guardian of child/student, or student if age 18 or older Date

Submit this form to the child care program, school or college.

070116

VERMONT
DEPARTMENT OF HEALTH

College Immunization Exemption

Vermont's Immunization Rule, adopted pursuant to 18 V.S.A. § 1123, applies to undergraduate students enrolled in colleges and universities. Before entry, students must have the required immunizations unless exempt for medical or religious reasons. In order to claim either exemption this form must be completed and returned to the student health center prior to school attendance.

Students who claim any exemption may be kept out of classes during the course of a disease outbreak if it is determined that such students are at risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes will vary depending on the disease, and can range from several days to more than a month.

Complete all information below on behalf of the student named. This form may not be altered.

_____ _____/_____/_____
Student first and last name Date of birth

MEDICAL EXEMPTION

Check only the specific vaccine(s) that is or may be detrimental to the patient's health:

☐ **Hepatitis B**	☐ **Td/Tdap**	☐ **Varicella**	☐ **Meningococcal** 1st year dormitory residents only
☐ **Measles**	☐ **Mumps**	☐ **Rubella**	

Reason for medical exemption(s):_____

This exemption will likely continue until: _____/_____/_____.

The law requires that the student receive the vaccine(s) for which they are exempted when the vaccine(s) is no longer contraindicated.

_____ (____)_____
Print Name of Health Care Practitioner* **Telephone**

_____ ___/___/_____
Signature of Health Care Practitioner* **Date**

*According to Vermont statute, only a health care practitioner authorized to prescribe vaccines may sign the medical exemption form.

RELIGIOUS EXEMPTION

In signing this form I attest to holding religious beliefs opposed to immunizations. I acknowledge that I have reviewed evidence-based educational material provided by the Vermont Department of Health regarding immunizations including: information about the risks of adverse reactions to immunization; information that failure to complete the required vaccination schedule increases risk to the person and others of contracting or carrying a vaccine-preventable infection; and information that there are persons with special health needs who are unable to be vaccinated, or who are at heightened risk of contracting a vaccine preventable communicable disease, and for whom such a disease could be life-threatening. I request exemption from the vaccine(s) checked below:

☐ **Hepatitis B**	☐ **Td/Tdap**	☐ **Varicella**	☐ **Meningococcal** 1st year dormitory residents only
☐ **Measles**	☐ **Mumps**	☐ **Rubella**	

_____ (_____)_____ ____/___/_____
Signature of Student (or parent if under 18 years) **Telephone** **Date**