1. Information on this form is CONFIDENTIAL and solely for the Health Services and will not be released without the student’s consent.
2. A Late fee of $75.00 will be charged for failure to submit completed Health Forms by the required August 4, 2023 deadline.
3. Health insurance must be purchased or waived online by visiting Haverford College Health Services > Insurance.
4. Exam must be completed after January 1 by a Health Care Professional* (may not be completed by a parent).

*Varsity Athletes: Physical must be completed after February 1

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**MEDICATIONS – ATTACHED ADD’L DOCUMENTATION IF REQUIRED**

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Instructions</th>
<th>Indication</th>
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Questions or Comments?
Ph: 610-896-1089
Fax: 833-846-6925
Email: hc-healthservices@haverford.edu
Pennsylvania Department of Health: School

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Per Pennsylvania State law for schools:

Haverford College follows the American College Health Association (ACHA), the Pennsylvania State Mandatory Vaccination Code,

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Definition of Vaccinated

For the purposes of these policies, a “vaccinated” Haverford employee or student means that the individual has provided documentation to the College that, no later than two weeks of becoming eligible, they have received a booster dose (Pfizer or Moderna) following an FDA-authorized (Pfizer, Moderna, or Johnson & Johnson) COVID-19 vaccine. The College will also accept a different WHO-approved vaccine as satisfying the initial vaccine requirement, with the accompanying strong recommendation from the College and its medical advisors that such vaccinated individuals also gain an FDA-authorized vaccine. All Haverford faculty, staff, and students are required to be vaccinated with boosters or to receive a medical or religious exemption per the COVID-19 Vaccine Policy.

For more information regarding Haverford College's vaccination requirement for students, please visit https://www.haverford.edu/access-and-disability-services

MEDICAL CLEARANCE REQUIREMENTS FOR PARTICIPATION IN VARSITY ATHLETES

Sickle Cell Requirement

This is an NCAA requirement that Haverford College requires from all of its varsity athletes. Upload a blood test confirming your Sickle Cell status into your HaverHealth Portal by August 1, 2022 and use the tag “Sickle Cell Lab Results” For students born in the United States, in many cases this testing has been done at birth and results should be available via the birth hospital or pediatrician. You can use this link to find the information from the CDC specific to the state of your birth, whether you were screened, and the forms to request that result. If you would like, you can have that test result faxed to: Curt Mauger Head Athletic Trainer Haverford College 833-570-8643 (fax)

For incoming students who were born abroad, who cannot obtain previous testing, or who cannot arrange to be tested prior to their arrival on campus, testing for Sickle Cell Trait can be arranged through Haverford's Health Services.

IMMUNIZATION RECORD

Definition of Vaccinated

For the purposes of these policies, a “vaccinated” Haverford employee or student means that the individual has provided documentation to the College that, no later than two weeks of becoming eligible, they have received a booster dose (Pfizer or Moderna) following an FDA-authorized (Pfizer, Moderna, or Johnson & Johnson) COVID-19 vaccine. The College will also accept a different WHO-approved vaccine as satisfying the initial vaccine requirement, with the accompanying strong recommendation from the College and its medical advisors that such vaccinated individuals also gain an FDA-authorized vaccine. All Haverford faculty, staff, and students are required to be vaccinated with boosters or to receive a medical or religious exemption per the COVID-19 Vaccine Policy.

For more information regarding Haverford College's vaccination requirement for students, please visit https://docs.google.com/document/d/1pNj9auftISYFc4kqDTx6pG5OLHBUMz2vuc9G8fiY8E/edit

IMMUNIZATION EXEMPTION(S): DECISION NOT TO VACCINATE: https://www.haverford.edu/sites/default/files.Office/Health-Services-Decision-not-to-Vaccinate.pdf

Haverford College follows the American College Health Association (ACHA), the Pennsylvania State Mandatory Vaccination Code, the Advisory College of Immunization Practices (ACIP) and the CDC's recommendations for immunization compliance guidelines. For the safety of all students, faculty and staff, immunizations are mandatory. Students may be exempted from the immunization requirements if there is a medical contraindication or if the student’s religious or philosophical belief prohibits immunizations.

Per Pennsylvania State law for schools:

(a) Medical exemption. Children need not be immunized if a physician or the physician’s designee provides a written statement that immunization may be detrimental to the health of the child. When the physician determines that immunization is no longer detrimental to the health of the child, the child shall be immunized according to this subchapter.

(b) Religious exemption. Children need not be immunized if the parent, guardian or emancipated child objects in writing to the immunization on religious grounds.

For more information regarding Pennsylvania's vaccination requirements for students, please visit the following resources: Pennsylvania Department of Health: School Immunizations; 28 Pa. Code § 23.84: Exemption from immunization.
REQUIRED:

1. MEASLES (RUBEOLA), MUMPS AND RUBELLA (GERMAN MEASLES)
   Dose #1 ___/___/____ Dose #2 ___/___/____
   **OR**
   MMR Titer *must attach laboratory results  Date of Titer: ___/___/____  Result: __________

2. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) (MCV) 1 Dose required after 16 years of age.
   Dose #1 ___/___/____ Dose #2 ___/___/____

3. SEROGROUP B MENINGOCOCCAL
   MenB-RC (Bexsero) Dose #1 ___/___/____ Dose #2 ___/___/____  **At least 2 months after Dose 1 OR**
   MenB-FHbp (Trumenba) Dose #1 ___/___/____ Dose #2 ___/___/____  **At least 2 months after Dose 1**

4. TETANUS, DIPHTHERIA, PERTUSSIS
   Primary series completed? Yes ___ No ___ Date of most recent Tdap: ___/___/____

5. COVID-19 Bivalent – One (1) required bivalent dose after 9/1/2022.
   Bivalent: ___/___/____  □ Pfizer  □ Moderna

6. HEPATITIS B
   Immunization (hepatitis B)
   Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____
   Immunization (Combined hepatitis A and B vaccine)
   Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____
   **OR**
   HEPATITIS B Titer *must attach laboratory results  Date of Titer: ___/___/____  Result: __________

7. VARICELLA
   Dose #1 ___/___/____ Dose #2 ___/___/____
   **OR**
   Varicella Titer *must attach laboratory results  Date of Titer: ___/___/____  Result: __________
   **OR**
   Date of Disease: ___/___/____

8. POLIOMYELITIS (POLIO) – Completed Primary Series
   Primary series completed? Yes ___ No ___ Date of most recent OPV/ IPV Dose: ___/___/____

RECOMMENDED IMMUNIZATIONS:

1. COVID-19 Primary Monovalent Series
   Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____
   □ Pfizer  □ Moderna  □ Other: __________________________

2. HEPATITIS A
   Dose #1 ___/___/____ Dose #2 ___/___/____
   **(Combined hepatitis A and B vaccine)** Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____

3. PNEUMOCOCCAL VACCINES
   PCV 13 Date ___/___/____
   PPSV 23 Date ___/___/____

4. HUMAN PAPILLOMAVIRUS VACCINE
   Immunization (indicate which preparation, if known) 9-valent (HPV9) _____ or other _____
   Dose #1 ___/___/____ Dose #2 ___/___/____ Dose #3 ___/___/____
### TUBERCULOSIS RISK ASSESSMENT (TBRA)

**SECTION 4: TO BE COMPLETED BY HEALTH CARE PROVIDER**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever had a positive tuberculosis (TB) test?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do you have any of the following signs or symptoms of active TB disease?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Do any of the following situations apply to you?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Within the past 5 years, have you traveled to or living in any of the following areas for more than one month?</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If you checked any boxes in column two, TB testing is required. American Academy of Pediatrics (AAP) recommends either a TST or TB blood test (interferon-gamma release assay [IGRA]).

<table>
<thead>
<tr>
<th>Test</th>
<th>Date of Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quantiferon-TB Gold Plus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T-SPOT®.TB</td>
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<td></td>
</tr>
</tbody>
</table>

Chest X-Ray required only if Tuberculin Skin Test or IGRAs positive. Date of X-Ray _________ Results: ___Negative ___Positive

If free of active disease, consider treatment for latent TB illness.


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**Provider Name (Print Clearly):**

**Provider Signature:**

**Assessment Date:**

**Practice Name/ Practice Stamp:**

**Address:**

**Phone:**

**Fax:**

This completed exam form can be faxed to 833-846-6925. 3/23