LANCASTER BIBLE COLLEGE
CAPITAL SEMINARY & GRADUATE SCHOOL

Penn Medicine
Lancaster General Health

LBC Physical Examination Form

INSTRUCTIONS AND INFORMATION:

To be completed by your primary care physician and returned prior to your first day of classes. Athletes must have this completed yearly. Once completed, please upload to your MyLBC account or fax to the nurse at the Student Wellness Center at 717-560-8204. Visit "step 5" at https://www.lbc.edu/undergraduate/accepted-student/ for instructions on how to upload to your MyLBC account.

FAMILY/LAST NAME | **GIVEN/FIRST NAME** | **PREFERRED NAME** | **MIDDLE NAME** | **GENDER** | **DATE OF BIRTH**

HOME ADDRESS (NUMBER AND STREET) | **CITY OR TOWN** | **STATE** | **ZIP CODE**

PREFERRED EMAIL (FANDM EMAIL WILL BE THE EMAIL OF RECORD ONCE YOU ARRIVE ON CAMPUS) | **HOME PHONE** | **STUDENT CELL PHONE**

EMERGENCY CONTACT NAME (RELATIONSHIP TO STUDENT) | **CONTACT PHONE NUMBER (HOME/WORK)**

MEDICAL HISTORY

PERSONAL:

Please check if you currently have or have a history of conditions listed below: Please explain all yes answers on line provided below.

Yes	No			Yes	No	
		Neurologic conditions – migraines, seizures, concussions				ADD/ADHD
		Depression/Anxiety/eating disorder history				Lung Disease – Asthma, recurrent Bronchitis/pneumonia, Tuberculosis etc
		Intestinal Disease – Crohns, Ulcerative colitis, peptic ulcer disease, dietary issues				Cancer
		Hematologic – anemia, clotting disorder, sickle cell				Heart Disease – high blood pressure, murmurs, congenital abnormalities, birth defects, disabilities etc,
		Endocrine disorders – thyroid conditions, Diabetes				Liver Disease – hepatitis, jaundice, gallbladder disease
		Dermatologic – problematic acne, rashes, etc				Orthopedic – joint or muscles conditions, arthritis, major injuries
		ENT – Recurrent Sinus infections, Strep throat or ear infections Describe:				GYN – menstrual disorder, ovarian cysts
		Eye conditions?				Have you ever had a sexually transmitted infection?
		Have you every taken any illegal or recreational drugs or medications not prescribed for you?				Do you drink Alcohol? If so, how many drinks/week on average?
		Do you smoke? Cigarettes or E-cigs? Marijuana?				Are you concerned about your weight? Too heavy? Too thin?
		Did you have covid? Date(s):				Do you participate in regular exercise program?

Please explain above "Yes" answers:

_____

Allergies: Yes or No; If Yes, please list below:
Medications: _____
Foods: _____
Environmental: _____
Do you have an Epi Pen?: _____

Does the student require a special diet? Yes or No; If yes, please list diet:

_____

Please list any current medications:

_____
_____
_____

List any pertinent surgeries/hospitalizations or injuries:

_____
_____
_____

Clearance for Sports Participation:
Participating in _____
Cleared for full participation _____
Cleared after completing the evaluation/rehabilitation for _____
Not cleared/May not participate _____
N/A _____

Is the patient under any treatment now for medical or emotional conditions? Please list:

_____
_____
_____
_____

IMMUNIZATIONS

FOR FIRST YEAR STUDENTS ONLY:
Record Immunizations: Every item on this page must be completed by your primary care provider prior to attending class at Lancaster Bible College. *An attached immunization record that include the required immunizations below is acceptable.*

REQUIRED Immunization:
Meningococcal Vaccine: MUST BE COMPLETED or waived - Failure to provide a record of meningococcal will result in being delayed in moving into a resident hall per PA Mandate. (www.immunize.org/laws/menin.asp)

Meningococcal Vaccine Pennsylvania State law provides that a student at an institute of higher education may not reside in a dormitory or campus housing unit unless the vaccination against meningococcal disease has been received, or a student (parent or guardian for minors) may sign a written waiver verifying they have chosen not to receive the meningococcal disease vaccination for religious or other reasons. Please review the links below for information and risk for meningitis - https://www.cdc.gov/meningitis/bacterial.html

Meningococcal Vaccine (Menactra/Menveo)
First_____/_____/_____ Second _____/_____/_____
OR
Meningococcal waiver:
I, (student's name printed) _____, received and reviewed the information provided by the above links regarding meningococcal disease or that the doctor has shared with me. I am fully aware of the risks associated with meningococcal disease and of the availability and effectiveness of the vaccinations against the disease. I wavier the meningococcal disease vaccine at this time.
(student's signature): _____

Highly Recommended Immunizations:

Meningitis B

First _____/_____/_____ Second _____/_____/_____

MMR (Measles, Mumps, Rubella) - MMR encouraged related to increased local outbreaks

First_____/_____/_____ Second_____/_____/_____

(Those born before 1957 are considered immune to measles, mumps and rubella)

Polio

First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____ Latest Booster_____/_____/_____

Diphtheria, Tetanus, Pertussis

First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____ Latest Booster_____/_____/_____

Varicella:

First_____/_____/_____ Second_____/_____/_____ or disease date _____/_____/_____

Hepatitis B:

First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____

HPV:

First_____/_____/_____ Second_____/_____/_____ Third: _____/_____/_____

TUBERCULOSIS (TB) RISK ASSESSMENT— REQUIRED ONCE FOR INCOMING STUDENTS

The American College Health Association has published guidelines on TB screening of college students that are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information visit www.acha.org (search by term TB) or refer to CDC's Q&A about TB at https://npin.cdc.gov (search by term TB).

1. Have you ever had a positive tuberculosis skin test or blood test in the past?..... Yes or No (please circle one)
2. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis?..... Yes or No (please circle one)
3. Were you born in a country listed below?*..... Yes or No (please circle one)

   If yes, did you arrive in the U.S. within the past 5 years?..... Yes or No (please circle one)
4. Have you traveled or lived for more than one month in any country listed below?*..... Yes or No (please circle one)
5. Have you ever had changes on a prior chest X-ray suggesting inactive or past TB disease? ..... Yes or No (please circle one)
6. Do you have a medical condition associated with increased risk of active TB if exposed: diabetes, chronic renal failure, leukemias or lymphomas, low body weight, HIV/AIDS, gastrectomy or intestinal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone>15mg/day for>1 month), other immunosuppressive disorders, or are you an organ transplant recipient?..... Yes or No (please circle one)

7. Have you been a volunteer, employee or resident in a high-risk congregate setting such as a prison, nursing home, hospital, homeless shelter, residential facility or other health care facility in the past 12 months?..... Yes No

8. Do you have a history of illicit drug use?..... Yes or No (please circle one)

9. Have you ever received BCG vaccine?..... Yes or No (please circle one)

* Angola, Bangladesh, Brazil, Cambodia, China, Congo, Central African Republic, DPR Korea, DR Congo, Ethiopia, India, Indonesia, Kenya, Lesotho, Liberia, Mozambique, Myanmar, Namibia, Nigeria, Pakistan, Papua New Guinea, Philippines, Russian Federation, Sierra Leone, South Africa, Thailand, United Republic of Tanzania, Vietnam, Zambia, Zimbabwe - ** The significance of the travel exposure should be discussed with a health care provider and evaluated.*

If you answer NO to all of the above questions, no further action is required. If you answer YES to any of the above questions, you are REQUIRED to have either Interferon Gamma Release Assay (preferred) or Mantoux tuberculin skin test (TST) *within 6 months prior to beginning classes, unless a previous positive test has been documented. Prior BCG does not exempt students from the requirements.*

TB SKIN TEST Use Mantoux test only —OR— TB BLOOD TEST ----or------ CHEST X-RAY*

Mantoux skin test/PPD		TB blood test
TB skin test		Quantiferon:
Date placed:		Date::
Date read:		Results:
Duration: mm		

Chest X-ray	Medication Treatment for TB
Date:	Medication:
Results:	
Required for positive blood tests	Treatment completion Date:

**** 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-a
- 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, diabetic 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 College reserves the right to require further testing for tuberculosis screening based on risk. Students who study abroad or travel in high prevalence areas should be screened for tuberculosis after their return. Screening tests for tuberculosis are available at the Student Wellness Center.

The information on this physical form is accurate and complete to the best of my knowledge.

Student signature _____ Date of Birth: _____

Date: _____

Provider's Name (Print)_____

Provider's Signature _____License number_____

Practice Name _____

Office Address_____

Phone _____ Fax_____ Date _____

(CONTINUE to page 5-8 for LBC Athletes ONLY)

_____

LAST NAME FIRST NAME DOB

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AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

To be completed by Parent/Guardian and Student-Athlete

I hereby authorize Lancaster Bible College Athletic Staff to release or disclose information to parties in the event of an emergency or in the event that coordinated care is necessary. I understand that protected health information will not be shared with anyone without the consent of the student-athlete, except when necessary. I also understand that my information will be protected from being released through all reasonable means. Lancaster Bible College Athletics' policy is to ensure that information is protected and remains confidential.

Through the course of participation it is necessary for information to be shared between athletic trainer and coach. I acknowledge that this is necessary. I also acknowledge that it is the policy of Lancaster Bible College that information may be shared between medical personnel within Lancaster Bible College.

_____ _____

Signature of Parent/Guardian (if under 18 years of age) Signature of Student-Athlete

_____ _____

Date Date

_____

LAST NAME FIRST NAME DOB

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CONSENT AND RELEASE FOR PARTICIPATION IN ATHLETICS

To be completed by Parent/Guardian and Student-Athlete

Lancaster Bible College's Athletic Program, while voluntary, is an integral part of the curriculum. College personnel have devoted great effort to assure that participating student-athletes are protected in every way possible. However, participation in athletics includes a risk of injury which may range in severity from minor to long-term catastrophic injury, including paralysis and even death.

Participants have the responsibility to help reduce the chance of injury. Participants must obey all safety rules and regulations and report all physical problems to the coach or athletic trainer. They must follow a proper conditioning program and inspect all personal protective equipment daily. Proper execution of skill techniques must be followed for every sport, especially in contact sports. Coaching staff will instruct players concerning skills and rules in their sports.

By initialing each statement below and signing at the bottom, I state that I have read, understand, and approve the above statements.

_____ I consent to (have my son/daughter) represent Lancaster Bible College in approved athletic activities except those activities excluded by the examining doctor.

_____ I grant permission for my son/daughter/self to accompany any college team in which he/she/I participates to out-of-town trips. The athlete will be transported to and from all events in college approved vehicles. Parents/guardians wishing to have their son/daughter traveling with them when returning from an event must make written arrangements with the coach.

_____ In the event of an emergency requiring medical attention, I expect every reasonable attempt to be made to contact parents. In an emergency, I grant permission for any immediate treatment deemed necessary by the attending physician and transfer of my son/daughter/self to a qualified medical facility.

_____ Because of the conditions inherent in sport, participating in sports exposes an athlete to many risks of injury. Those injuries include, but are not limited to death; paralysis due to serious neck and back injuries; brain damage; damage to internal organs; serious injuries to the bones, ligaments, joints, and tendons; and general deterioration of health. Such injuries can result not only in temporary loss of function, but also in serious impairment of future physical, psychological, and social abilities, including the ability to earn a living.

_____ I grant permission to the Athletic Training Staff and its medical representatives to render and/or obtain treatment, medical/surgical procedures to the extent of their abilities and training necessary to my (son's/daughter's) health and well being. Also, I grant permission for such established treatments and therapy be employed as may be deemed medically necessary or advisable in the diagnosis and treatment of my (son's/daughter's) illness or injuries sustained through participation in Intercollegiate Athletics.

_____
Signature of Parent/Guardian (if under 18 years of age)

_____
Signature of Student-Athlete

_____
Date

_____
Date

_____
LAST NAME FIRST NAME DOB

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STATEMENT ON INSURANCE COVERAGE

To be completed by Parent/Guardian and Student-Athlete

Sports activities have varying degrees of risk of injury that participants should recognize by the nature of the activity. Students who choose to participate in the intercollegiate sports program are encouraged to have personal insurance coverage. Most students are covered by their parents' policy. Lancaster Bible College Athletic Department has an excess insurance policy on all sports participants; however, it acts as a secondary carrier for athletic injuries only.

Insurance Claims Policies

1. Any medical or dental services associated with the care of injuries sustained during participation in intercollegiate athletics must be arranged through the athletic trainer. In emergencies, if the athletic trainer is not available, the student should consult the Student Health Services. An athlete who is injured in a practice or a contest should report the injury to the athletic trainer as soon as possible. Delay may result in the insurance declining the claim.

2. All care must be arranged through the athletic trainer. Individuals injured while participating in intercollegiate athletics may not be reimbursed for unauthorized services.

3. Written authorization and all necessary paperwork will be given by the athletic trainer for referral to the appropriate physician or healthcare provider. If this documentation is not on file in the athletic training office, bills for services may not be considered and the athlete may be responsible for payment.

4. If a student-athlete is injured while participating in a game, scrimmage, or practice sanctioned by the athletic department or in transit to or from the event, the policy with regards to insurance coverage as a student is as follows:

   A. All undergraduate students carrying twelve or more credits are required to have health insurance. Students must prove coverage through parent, spouse, or employer.

   B. The secondary policy that the college has for each student-athlete requires that the insurance that the student has be applied first to pay for any medical/dental and hospital costs that are covered through the insurance. Procedures for filing a claim through personal insurance must be followed. If not, a delay in payment or denial may result.

   C. The secondary policy is an "excess coverage plan" over any current insurance coverage by the student or their parents. This policy will pay the remaining eligible charges if there are any limits to personal coverage on the student.

   D. The athletic trainer will coordinate insurance coverage matters for all student-athletes. The injured athlete is responsible for filling out an insurance claim form with the athletic trainer and submitting any medical paperwork, bills or insurance paperwork immediately upon receipt. All claims must be filed within a specific period of time from the date of initial treatment for the injury.

5. If a serious injury should occur to an athlete while representing Lancaster Bible College in a sanctioned game, scrimmage, meet, or tournament, for which treatment cannot await the return to campus, appropriate medical attention should be sought and the athletic trainer notified immediately.

I, _____, have read and understand the insurance claims policies and know that Lancaster Bible College, the Athletic Department, or any office of Lancaster Bible College is not responsible for medical bills and if guidelines are not followed, I or my parents may be held financially responsible.

_____ _____

Signature of Parent/Guardian (if under 18 years of age) Signature of Student-Athlete

_____ _____

Date Date

_____

LAST NAME FIRST NAME DOB

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Sickle Cell Trait for NCAA Intercollegiate Athletics

About Sickle Cell Trait

- Sickle cell trait is an inherited condition affecting the oxygen-carrying substance, hemoglobin, in the red blood cells.
- In 2009, there were approximately four million Americans and 300 million people worldwide with sickle cell trait*.
- Although sickle cell trait occurs most commonly in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ethnicities may test positive for this condition.
- Unlike persons with actual sickle cell disease, those with sickle cell trait usually have no symptoms or any significant health problems. However, sometimes during very intense, sustained physical activity, as can occur with collegiate sports, certain dangerous conditions can develop in those with sickle cell trait, leading to blood vessel and organ (kidneys, muscles, heart) damage that can cause sudden collapse and death. Some of the settings in which this can occur include timed runs, all out exertion of any type for 2 to 3 continuous minutes without a rest period, intense drills and other bursts of exercise after doing prolonged conditioning training. Extreme heat and dehydration increase the risks.

Sickle Cell Trait Testing

- The NCAA requires** that all student-athletes have knowledge of their sickle cell trait status. Athletes have the following options: 1) show proof of sickle cell testing done at birth, OR 2) consent to a blood test to check for the sickle cell trait. Whichever option is chosen, it must be completed before the student-athlete participates in any intercollegiate athletic event, including strength and conditioning sessions, try-outs, practices, or competitions.
- • Athletes who are positive for the trait will not be prohibited from participating in intercollegiate athletics.

1.) Copy of student athlete's newborn screening sickle cell testing result attached. _____ Date of Test:_____

2.) Copy of recent sickle cell screening test result attached. _____ Date of Test: _____

SICKLE CELL TESTING AGREEMENT:

I, _____, understand and acknowledge that the NCAA requires** that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts and the College policy about sickle cell trait and sickle cell trait testing. Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Lancaster Bible College's Student Health Service Office and Athletics Department I have read and signed this document with full knowledge of the importance of sickle cell trait and the attachment of a newborn OR recent sickle cell screening testing result.

SPORT: _____

_____	_____	_____
Student-Athlete's Signature	Student-Athlete's Print Name	Date
_____	_____	_____
Parent/Guardian's Signature (if under 18 years of age)	Parent/Guardian's Print Name	Date

* See the following link by the CDC for more information and an additional link for student athletes: https://www.cdc.gov/ncbddd/sicklecell/traits.html

** The NCAA sickle cell testing requirements changed for all incoming student athletes for the start of the Fall Semester 2022 and after. Previous Lancaster Bible College Sickle Cell Trait for NCAA Intercollegiate Athletics Sickle Cell Testing Waivers signed prior to May 31, 2022 will be honored through the end of their NCAA eligibility.

_____

LAST NAME FIRST NAME DOB