ENDICOTT COLLEGE

376 Hale Street • Beverly, Massachusetts 01915

www.endicott.edu ~ Student Life ~ Health Center ~ 978-232-2104

HEALTH FORM

2013–2014

PLEASE NOTE:

ALL STUDENTS must see that this form is completed, signed, and returned to the Health Center
NO LATER THAN JULY 15 FOR FALL SEMESTER OR JANUARY 15 FOR SPRING SEMESTER.
Mail to: Endicott College Health Center, 376 Hale Street, Beverly, MA 01915 or FAX to 978-998-8004
Any student failing to do so will be prohibited from attending classes or residing on campus.
We recommend that you make and keep a copy of this form for your records.
Your health information is confidential and protected by state and federal law. The Endicott College Health Service is dedicated to protecting your rights.
ALL ATHLETES MUST MAKE A COPY OF THIS ENTIRE FORM AND SEND IT TO THE ATHLETIC DEPARTMENT.

SECTION I: STUDENT INFORMATION

To be completed by student

Name of Student _____ Endicott ID # _____
Last First Middle

Date of Birth _____/_____ /_____ Gender _____ Place of Birth _____
Month Day Year Country

Permanent Street Address _____

City _____ State _____ Zip Code_____

Student's Telephone Numbers: home (_____) _____ cell (_____) _____

❒ Undergraduate Student ❒ Graduate Student Student's Email _____

TO BE SIGNED BY STUDENT

I grant permission to Endicott College Health Services to release a copy of this Health Form to relevant personnel within the College for the purpose of obtaining information required for my major and/or athletic involvement. I understand that Endicott College cannot be held responsible for the accuracy of the information contained herein.

Student Signature_____ Date _____

EMERGENCY CONTACTS

Name _____ Relationship to Student _____

Permanent Street Address _____

City _____ State _____ Zip Code_____

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

Name _____ Relationship to Student _____

Permanent Street Address _____

City _____ State _____ Zip Code_____

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

CONSENT FOR EMERGENCY TREATMENT

To be signed by parent/guardian <u>if student is under 18 years of age</u>

I give permission for medical treatment for my son/daughter if an accident/illness should occur while he/she is a student at Endicott College. This includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I cannot to be reached.

Parent/Guardian Name (print)_____ Relationship to Student _____

Parent/Guardian Signature _____ Date_____

HEALTH INSURANCE INFORMATION (REQUIRED)

Please attach a photocopy of the front and back of your health insurance card.

In accordance with Massachusetts state law, students must provide proof of health insurance that is current and valid.

Insurance Company _____ ID# _____ Group# _____

Name of Subscriber _____ Subscriber Date of Birth _____

Please bring to campus information about deductibles, co-pay amounts, and referrals required by your insurance provider.

SECTION II: MEDICAL HISTORY

To be completed and signed by health care provider at time of examination

Student Name _____ Date of Birth _____

FAMILY HISTORY

	Age	State of Health	Age at Death	Cause of Death	Have any of your immediate relatives had any of the following?	Yes	Relationship
Father					Accident		
Mother					Alcoholism/Drug Issues		
Brothers					Blood Clots		
					Cancer		
Sisters					Diabetes		
					Heart Disease		
Spouse					High Blood Pressure		
Children					Neuromuscular Disorder		
					Mental Illness/Suicide		

PAST MEDICAL HISTORY *Please give dates and explain below. Use additional pages if necessary.*

Abnormal Pap		Counseling		Malaria	
Acne		Deaf/Hearing Impairment		Migraines/Chronic Headaches	
ADD (Attention Deficit Disorder)		Depression		Mononucleosis	
ADHD		Diabetes		Neuromuscular Disease	
Alcohol/Drug Issues		Eating Disorder		Painful Cramps	
Allergies - Environmental		Emotional/Mental Illness		Panic Attacks	
Allergies - Seasonal		Gastritis		Pelvic Inflammatory Disease	
Anemia		Genital Herpes (HSV)		Phlebitis/Deep Vein Clot	
Anorexia Nervosa/Bulimia		GERD (Gastro-Esophageal Reflux)		Pneumothorax	
Anxiety		Heart Disease/Problem		Positive TB Test	
Appendectomy		Hepatitis		Seizures Disorder	
Arthritis		Herpes		Sexually Transmitted Infection (STI)	
Asthma		High Blood Pressure		Sickle Cell Disease	
Bipolar Illness		High Cholesterol		Skin Conditions	
Blind/Visual Impairment		HIV Infection/disease		Stroke	
Blood Clots		Hives		TB/Tuberculosis	
Breast Disease		HPV (Human Papilloma Virus)		Thyroid Disease	
Breast Lumps		Impaired Mobility/Paralysis		Ulcer/Stomach Problems	
Cancer/Malignancy		Irregular Menstrual Cycle/No Period		UTIs (Frequent/Recurrent)	
Chickenpox		Kidney Disease		Warts	
Cigarette Smoking		Kidney Stone		Other	
Colitis/Ileitis		Learning Disability		NO SIGNIFICANT PAST MEDICAL HISTORY	
Contraception		Liver Disease			

Explain history: _____

_____

HOSPITALIZATIONS/SURGICAL PROCEDURES

1. _____ 2. _____ 3. _____

MEDICATIONS *Please list all prescriptions and OTC including birth control, asthma meds, and antidepressants.*

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

ALLERGIES TO MEDICATIONS *Please explain type of reaction*

1. _____ 2. _____ 3. _____

OTHER ALLERGIES *Please explain type of reaction*

1. _____ 2. _____ 3. _____

HEALTH CARE PROVIDER

Name (print) _____ Signature _____

Address _____ Phone _____ Fax _____

SECTION III: IMMUNIZATION RECORD

To be completed and signed by health care provider at time of examination

Student Name _____ Date of Birth _____

MASSACHUSETTS LAW (College Immunization Law, Chapter 76, Section 15c) and Endicott College require verification of immunity for measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, and varicella. Exact dates are required for all immunizations and/or serological test results. **If serology titer is done, please attach copy of report.** If serology titer indicates lack of immunity, vaccines must be administered. Immunizations administered prior to first birthday are invalid. History of diseases is not acceptable documentation of immunity, except for varicella. No documentation for varicella is required for those born before 1980.

I. REQUIRED IMMUNIZATIONS

Month / Day / Year

A. MMR (Measles, Mumps, Rubella): Two doses required

❒ Dose 1 Immunized on or after first birthday — Dose 1 _____/_____ /_____

❒ Dose 2 Given at least one month after Dose 1 — Dose 2 _____/_____ /_____

or

Documentation of positive antibody titer

Measles titer: Date _____/_____ /_____

Mumps titer: Date _____/_____ /_____

Rubella titer: Date _____/_____ /_____

B. Tetanus, Diphtheria Pertussis (Tdap) — Tdap _____/_____ /_____

Only one dose is required in last five years for 1st, 2nd, and 3rd year undergraduates

C. Tetanus, Diphtheria (Td) or (Tdap) — Td/Tdap _____/_____ /_____

One dose is required in last ten years for all 4th year students

D. Hepatitis B Vaccine: Three doses required — Dose 1 _____/_____ /_____

or — Dose 2 _____/_____ /_____

Documentation of a positive antibody titer (HBsAb) (attach copy of titer) — Dose 3 _____/_____ /_____

❒ Positive ❒ Negative Date _____/_____ /_____

E. Meningococcal Vaccine within the past five years

❒ Menactra Date: _____/_____ /_____

or

❒ Menveo Date: _____/_____ /_____

or

❒ Menomune Date: _____/_____ /_____

F. Varicella: Two doses required — Dose 1 _____/_____ /_____

or — Dose 2 _____/_____ /_____

Documentation of Varicella antibody titer (attach copy of titer)

❒ Positive ❒ Negative Date _____/_____ /_____

or

Documentation or reliable history of disease (Varicella) verified by a health care provider:

Provider name (print) _____ Signature _____ Date _____

or

❒ No documentation needed for those born before 1980

II. RECOMMENDED IMMUNIZATIONS

A. HPV Vaccine Dose 1 _____/_____ /_____; Dose 2 _____/_____ /_____; Dose 3 _____/_____ /_____

B. Hepatitis A Dose 1 _____/_____ /_____; Dose 2 _____/_____ /_____; Dose 3 _____/_____ /_____

C. Influenza Vaccine Date 1 _____/_____ /_____; Date 2 _____/_____ /_____; Date 3 _____/_____ /_____

III. REQUIRED IMMUNIZATIONS FOR NURSING AND ATHLETIC TRAINING MAJORS

A. Tuberculosis: PPD test within the past six months

Date _____/_____ /_____ PPD Result _____

If positive, X-Ray result _____ Is patient currently on medication? _____

HEALTH CARE PROVIDER

Name (print) _____ Signature _____

Address _____ Phone _____ Fax _____

Section IV: Physical Examination

To be completed and signed by health care provider at time of examination

Student Name _____ Date of Exam _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

System	Normal	Describe Abnormality
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular		
Abdomen (rectal if indicated)		
Genito/Urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		
Lab work recommended: Hgb/Hct _____ Cholesterol _____ Urine: Glucose _____ Protein _____ Micro _____		

Current and/or Chronic Problems

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Please Note: **If student is under care for a chronic condition or serious illness, please attach additional clinical reports to assist us in providing continuity of care.**

_____

_____

Special Dietary Requirements

_____

_____

Current Medications (Please list all prescriptions)

_____

_____

For Students with Disabilities (physical, psychological, or learning)

Please notify the office of Academic Resources/Center for Teaching and Learning at 978-232-2292.

MAIL THIS COMPLETED FORM TO:

Endicott College Health Center
376 Hale Street
Beverly, MA 01915

Phone: 978-232-2104 **Fax: 978-998-8004**

HEALTH CARE PROVIDER

Name (print) _____ Signature _____

Address _____ Phone _____ Fax _____