**SPRINGFIELD COLLEGE HEALTH CENTER**
263 Alden St., Springfield, MA 01109
(413) 748-3175 / (413) 748-3444 (fax)
healthcenter@springfield.edu

**Please do not submit partially completed forms.**

Health requirements are only considered fulfilled when all three pages have been successfully completed.

# HEALTH HISTORY FORM

**Forms are due no later than Dec. 15 for spring entry, April 15 for summer entry, and July 15 for fall entry.**
**PLEASE NOTE:** Full clearance for registration *will not* be granted until all health requirements are met.
I will be: __ First-year Undergraduate __ First-year Graduate __ Transfer __ NCAA Athlete (Sport: _____)

| | | | |
|---|---|---|---|
| **Name (last, first, middle):** | | | |
| **Identified Gender:** ☐ Male ☐ Female ☐ Transgender ☐ Other | | | |
| **Date of Birth:** | **Email:** | | |
| **Address:** | **City/State/Zip Code:** | | |
| **Telephone Numbers:** Home: | Cell: | | |
| **Emergency Contact**: Name: | Relationship: | Phone: | Alternate Phone: |

## MEDICATIONS/ALLERGIES

| |
|---|
| **CURRENT MEDICATIONS:** Name of Medication/Dosage |
| Medication Allergies: |
| Other Allergies: |

## PERSONAL HISTORY

| Have you ever had: | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| ADD/ADHD | | | Eye/Vision Disorder | | | Joint/Bone Disease | | |
| Anxiety/Depression | | | Eating Disorder | | | Kidney Disease | | |
| Asthma | | | Headaches/Migraines | | | Mononucleosis | | |
| Bleeding Disorder | | | Head Injury/Concussions | | | Seizures | | |
| Cancer | | | Heart Disease/Murmur | | | Sickle Cell Trait | | |
| Diabetes | | | High Blood Pressure | | | Tobacco Use | | |
| Dizziness/Fainting | | | High Cholesterol | | | Other | | |
| Ear/Hearing Disorder | | | Hospitalizations/Surgeries | | | | | |

Include date and year, description, and complications for each "yes" response (use separate page if needed).

_____

_____

## FAMILY HEALTH STATUS

| | Age | State of Health | Significant Illnesses |
|---|---|---|---|
| Father | | | |
| Mother | | | |
| Sibling(s) | | | |

**You MUST answer the following tuberculosis (TB) risk questions:**
Have you ever had close contact with anyone sick with TB? ☐ Yes ☐ No
Were you born in or lived for more than one month in any foreign country? ☐ Yes ☐ No
If you answered **YES** to either of the TB questions above, ***please print out the TB form and bring to your physical appointment*** **as you may need a TB skin test.**

**CONSENT FOR TREATMENT:** In case of serious illness or accident, I give Springfield College Health Center medical staff, or its representative(s), permission to secure medical and/or surgical care deemed necessary for my health. I authorize the Health Center medical staff to perform medical care and immunizations as deemed necessary by licensed personnel. Also, I have read the Notice of Privacy Practices, which pertains to the Health Insurance Portability and Accountability Act (HIPAA), disclosing how Springfield College may use and disclose my protected health information.

_____ _____

**STUDENT SIGNATURE** (or parent if student is under 18 on first day of classes) **DATE**

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# PHYSICAL EXAMINATION FORM

*(MUST BE COMPLETED BY A LICENSED MD, DO, NP or PA)*

*** May attach physical from healthcare provider but must include Provider Recommendations***

Admission requirement: Student must undergo physical exam within two years of start date.

**NCAA Athletes:** Please note that the NCAA requires physical examination within six months for sports clearances. Sickle cell screening is recommended for NCAA athletes (see athletic training forms).

**Student's Name** _____ **Date of Birth** _____

**Height** _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____ **Vision R 20/___ L 20/___ Corrected Y N**

| Physical Examination | Normal | Abnormal | Describe Abnormalities |
|---|---|---|---|
| General | | | |
| Skin | | | |
| HEENT | | | |
| Neck/Thyroid | | | |
| Chest and Lungs | | | |
| Cardiovascular | | | |
| Abdomen | | | |
| Genitals/Hernia | | | |
| Musculoskeletal | | | |
| Neurological/Psychiatric | | | |
| Other Significant Abnormalities | | | |

**Provider Recommendations *(MUST BE COMPLETED):***

- Is this individual currently under treatment for any medical or emotional conditions? Yes ☐ No☐
  - If yes, please specify. _____
- Do you have any recommendations regarding the care of this individual? Yes☐No☐
  - If yes, please specify.

    _____
- Recommendation for physical activity. Unlimited ☐Limited☐
  - If "limited," please specify. _____

Provider Signature _____ Date of Exam _____
Printed Name _____ MD/DO/NP/PA
Address _____
Telephone _____ Fax _____

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# Immunization Record

**Name** _____ **Date of Birth** _____

Massachusetts state law requires that all full-time students, all full- or part-time health science students, and all international students submit documentation of the following vaccinations:

(Please provide dates of vaccinations. Form *must* be signed by your health care provider.)

**Hepatitis B Vaccine #1** Month/Day/Year _____
**Hepatitis B Vaccine #2** (at least 30 days after first dose) Month/Day/Year _____
**Hepatitis B Vaccine #3** (four months after first dose or two months after second dose) Month/Day/Year _____

**MMR Vaccine #1** (on or after first birthday) Month/Day/Year _____
**MMR Vaccine #2** (at least one month after the first) Month/Day/Year _____
(Non-health science students born before 1957 are not required to complete MMR documentation.)

**Tetanus-Diphtheria Acellular Pertussis** (on or after seventh birthday) Month/Day/Year _____
Recommend updated Tdap/TD if greater than 10 years Month/Day/Year _____

**Varicella Vaccine #1** (on or after first birthday) Month/Day/Year _____
**Varicella Vaccine #2** (given more than four weeks after first dose) Month/Day/Year _____
*Or*
**Date of History of Disease** Month/Day/Year _____
(Students born before 1980 are not required to complete varicella documentation.)

**Meningococcal (MenACWY )** Month/Day/Year

_____
(***All*** students under age 21 must have meningitis vaccine on or after their 16th birthday, regardless of housing status.)

**Meningitis B** (two doses recommended but not required) Month/Day/Year _____
Month/Day/Year _____

*If dates of vaccinations are not available, you may **attach lab reports** of titer results for MMR, Hepatitis B, and Varicella.

**Failure to comply with Massachusetts immunization law will result in a hold on your registration.**

**Health Care Provider's Signature** _____ **Date** _____
**Printed Name** _____ MD/DO/PA/NP
**Address** _____
**Telephone** _____ **Fax** _____