



SMITH COLLEGE

Health Services

www.smith.edu/health

Full clearance for registration will not be granted until all pre-entrance medical requirements have been met. Please return this completed form by **JUNE 12, 2009.**

This information is **STRICTLY CONFIDENTIAL** and is requested so that we may provide the student with the best possible medical care. Return completed form to Director of Health Services, 69 Paradise Road, Northampton, MA 01063.

■ **PART I (To be completed by student and family)**

Name		Date of birth	
LAST	FIRST		MIDDLE INITIAL

Birthplace _____

Smith College class of	Smith College ID number
------------------------	-------------------------

Permanent address _____

Home telephone number ()	Student cell phone number ()
--------------------------------	------------------------------------

FAMILY MEDICAL HISTORY

Parent's name	Age	Health	Occupation
---------------	-----	--------	------------

Parent's name	Age	Health	Occupation
---------------	-----	--------	------------

Brothers (Ages)	Health
-----------------	--------

Sisters (Ages)	Health
----------------	--------

Children (Ages)	Health
-----------------	--------

Other important medical information:

THIS QUESTIONNAIRE IS CONFIDENTIAL.

PERSONAL MEDICAL HISTORY (To be completed by student)

Does student have any allergy to foods or drugs? Yes No

If so, list.

Give details and dates of all operations (including tonsils and adenoids). None

Give details and dates of accidents including dislocations, fractures and any injury with loss of consciousness. None

Has student ever lost one or more terms from school because of illness? Yes No

If so, give dates.

Has student been under the care of a specialist (medical or mental health) during the past year? Yes No

If so, indicate reason.

Does student have any chronic or congenital conditions? Yes No

If so, describe.

Does student take any medications? Yes No

If so, list.

Was student's mother given any hormone (especially DES) while pregnant with student? Yes No

If yes, what type?

Give age or ages at which student has had any of the following:

- | | | | |
|--------------------------------------|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> German measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Nervous breakdown | <input type="checkbox"/> Stomach or duodenal ulcer |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Infectious mononucleosis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatism or arthritis | <input type="checkbox"/> Urinary tract infection |

Other diseases (name):

■ **PART II (To be completed by student)**

Complete the following and, when appropriate, give an explanation.

Do you have ear trouble or defective hearing?

Do you have eye trouble or defective vision? Wear glasses? Contact lenses?

Do you have headaches, dizziness, seizures or fainting spells?

Do you have chest pain? Shortness of breath? Chronic cough? Wheezing? Heart murmur? Heart trouble?

Do you have abdominal pain? Any gastrointestinal problems? Bowel trouble? Hemorrhoids or rectal trouble?

Do you have kidney trouble?

Do you have any endocrine (glandular) problems (e.g. diabetes, thyroid)?

If so, what medication are you on?

Do you have pain or other trouble with your back, legs, feet, hands or joints?

Has your weight changed in the past six months? Gain? Loss? How much?

Why?

Do you have any concerns about food?

Menstrual history Age at onset: Usual interval between periods: Duration of flow:

Amount of pain (none, mild, moderate, severe) Medicine for pain? Name of medicine:

EMERGENCIES

Name of individual(s) to be contacted in an emergency who would be able to make treatment decisions. If the student is younger than 18, the legally responsible parent(s) or guardian must be listed first.

1. Relationship to student

Address

Daytime telephone number () Evening telephone number ()

2. Relationship to student

Address

Daytime telephone number () Evening telephone number ()

FINANCIAL RESPONSIBILITY AND CONSENT TO TREATMENT (must be signed by student and parent)

I hereby accept financial responsibility for the expense of health care services which are rendered to the aforementioned student by Smith College Health Services or such other health care provider as Smith College Health Services shall determine necessary or desirable.

I hereby give permission for the aforementioned student to receive general non-surgical medical treatment from Smith College Health Services or such other health care provider as Smith College Health Services shall determine necessary or desirable.

Signature of student (required)

Signature of legally responsible parent or guardian (required)

PART III (*this form* must be completed and signed by your health care provider)

RECORD OF IMMUNIZATIONS/TESTS

Name _____ Class _____ Date of birth _____

REQUIRED:

Massachusetts' law and/or Smith College require the following immunizations or tests for *all* entering students. **You will not be able to register for classes until this information has been provided. You must include the month, day and year, and this form must be signed and dated by a physician or nurse practitioner.**

TETANUS/DIPHTHERIA

*Primary series of 4 doses DTaP or DTP _____, _____, _____, _____
mm dd yy mm dd yy mm dd yy mm dd yy

*Td or Tdap booster (**circle which vaccine used**)—must have been done within the last 10 years _____
mm dd yy

POLIO Primary series in childhood meets the requirement—fill in the dates according to the series you received

1. OPV alone (oral Sabin 3 doses) _____, _____, _____
mm dd yy mm dd yy mm dd yy

2. IPV alone (injected Salk 4 doses) _____, _____, _____, _____
mm dd yy mm dd yy mm dd yy mm dd yy

3. IPV/OPV sequential IPV _____, IPV _____, OPV _____, OPV _____
mm dd yy mm dd yy mm dd yy mm dd yy

MEASLES, MUMPS, RUBELLA DOCUMENTATION

*Two doses each of measles and mumps, and one dose of rubella are required; either as trivalent vaccine or monovalent vaccine. The first dose must be given **on or after age 12 months**, the second must be at least one month later. *Or laboratory evidence of immunity (positive titer).

M.M.R. first dose _____ second dose _____
mm dd yy mm dd yy

or date of titer _____ Titer result _____ (attach copy of lab)
mm dd yy

OR

MEASLES first dose _____ second dose _____
mm dd yy mm dd yy

or date of titer _____ Titer result _____ (attach copy of lab)
mm dd yy

MUMPS _____ second dose _____
mm dd yy mm dd yy

or date of titer _____ Titer result _____ (attach copy of lab)
mm dd yy

RUBELLA _____
mm dd yy

or date of titer _____ Titer result _____ (attach copy of lab)
mm dd yy

HEPATITIS B (three doses or positive Hepatitis B surface antibody titers)

date _____, _____, _____ dosage _____ mcg
mm dd yy mm dd yy mm dd yy

or Hepatitis B surface antibody: date _____ Titer result _____ (attach copy of lab)
mm dd yy

TUBERCULOSIS SCREENING (Required):

Name _____
 Last First MI Date of Birth

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) Yes No

Have you ever traveled** to/in one or more of the countries listed below? (If yes, please CHECK the country/ies) Yes No

Have you ever been vaccinated with BCG? Yes No

**future CDC updates may eliminate the five-year time frame*

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

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Côte d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Tajikistan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tanzania-UR
Bahamas	El Salvador	Latvia	Palau	Thailand
Bahrain	Equatorial Guinea	Lesotho	Panama	Timor-Leste
Bangladesh	Eritrea	Liberia	Papua New Guinea	Togo
Belarus	Estonia	Lithuania	Paraguay	Tokelau
Belize	Ethiopia	Macedonia-TFYR	Peru	Tonga
Benin	Fiji	Madagascar	Philippines	Tunisia
Bhutan	French Polynesia	Malawi	Poland	Turkey
Bolivia	Gabon	Malaysia	Portugal	Turkmenistan
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Tuvalu
Botswana	Georgia	Mali	Romania	Uganda
Brazil	Ghana	Marshall Islands	Russian Federation	Ukraine
Brunei Darussalam	Guam	Mauritania	Rwanda	Uruguay
Bulgaria	Guatemala	Mauritius	St. Vincent &	Uzbekistan
Burkina Faso	Guinea	Mexico	The Grenadines	Vanuatu
Burundi	Guinea-Bissau	Micronesia	São Tomé & Príncipe	Venezuela
Cambodia	Guyana	Moldova-Rep.	Saudi Arabia	Viet Nam
Cameroon	Haiti	Mongolia	Senegal	Wallis & Futuna Islands
Cape Verde	Honduras	Montenegro	Seychelles	W. Bank & Gaza Strip
Central African Rep.	India	Morocco	Sierra Leone	Yemen
Chad	Indonesia	Mozambique	Singapore	Zambia
China	Iran	Myanmar	Solomon Islands	Zimbabwe
Colombia	Iraq	Namibia	Somalia	
Comoros	Japan	Nauru	South Africa	
Congo	Kazakhstan	Nepal	Spain	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2006, Countries with Tuberculosis incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to www.who.int/globalatlas/dataQuery/default.asp

If the answer is YES to any of the above questions, the Tuberculosis Medical Evaluation Form (see next page) must be completed. You are required to have a Tuberculin Skin Test/PPD (TST) or Interferon Gamma Release Assay (IGRA) within three months prior to enrollment in classes, unless a previous positive test has been documented.

If the answer to all of the above questions is NO, no further testing or further action is required.

Student signature _____ date _____

M.D./D.O./N.P./P.A. signature required _____ date _____

