

# 2009 Strings@Smith Program

## Medical Information/Record of Immunization/Parental Consent Form

This information is STRICTLY CONFIDENTIAL and is required for attendance in the 2009 [Strings@Smith](#) program, in order that the student may be provided with the best possible medical care. Return completed form to:

Jonathan Hirsh, Strings@Smith, Music Department, Smith College, Northampton, MA 01063.

**This form must be completed and returned by June 1, 2009.**

### Part I (to be completed by participant and parent)

Participant's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home telephone number (\_\_\_\_) \_\_\_\_\_ Fax number (\_\_\_\_) \_\_\_\_\_

Parent's/Guardian's name \_\_\_\_\_

Parent's/Guardian's address \_\_\_\_\_  
(if different from student's) *street* *apt. #*

*city* *state* *ZIP*

Parent's/Guardian's telephone (\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_

Cell number (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Parent's/Guardian's name \_\_\_\_\_

Parent's/Guardian's address \_\_\_\_\_  
(if different from student's) *street* *apt. #*

*city* *state* *ZIP*

Parent's/Guardian's telephone (\_\_\_\_) \_\_\_\_\_ Work Telephone (\_\_\_\_) \_\_\_\_\_

Cell number (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Name of another person to notify in case of emergency: \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

## PERSONAL MEDICAL HISTORY

Give details and dates of all operations (including removal of tonsils, adenoids) \_\_\_\_\_ None

---

---

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

---

---

Does student have any allergy to foods or drugs? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If so, list.

---

---

Has student ever missed one or more terms from school because of illness?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If so, indicate illness, give dates.

---

---

Has student been under the care of a specialist (medical or mental health) in the past?  
\_\_\_\_\_ Yes \_\_\_\_\_ No If so, indicate reason.

---

---

Does student have any chronic or congenital conditions? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If so, describe.

---

---

Does student take any medication? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, list.

---

---

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

_____ Asthma	_____ Eating disorder	_____ Measles	_____ Scarlet fever
_____ Chicken Pox	_____ German Measles	_____ Mumps	_____ Skin disorders
_____ Colitis	_____ Hay Fever	_____ Nervous breakdown	_____ Stomach Ulcer
_____ Convulsions	_____ Infectious mononucleosis	_____ Pneumonia	_____ Suicide attempt
_____ Depression	_____ Jaundice	_____ Rheumatic fever	_____ Tuberculosis
_____ Diabetes	_____ Malaria	_____ Rheumatism or arthritis	_____ Urinary Tract infection

Other diseases (*specify*) \_\_\_\_\_

**Where appropriate, circle the conditions or symptoms that you have and give a brief 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 taking? \_\_\_\_\_

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? \_\_\_\_\_

**HEALTH CARE PROVIDER AND INSURANCE INFORMATION**

Participant's Health Care Provider \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

Participant's Insurance Provider \_\_\_\_\_

Policy # \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

**PARENTAL CONSENT TO TREATMENT**

We/I understand that our/my son/daughter, \_\_\_\_\_, has been selected to attend the Smith Sings Program, to be held July 5-10, 2009, on the campus of Smith College, Northampton, Massachusetts. We do hereby request that the Smith Sings Program take whatever steps necessary to secure medical treatment of our/my child named above in the event she appears to be in need of such treatment while attending the Smith Sings Program. We consent to the rendering of all necessary treatment, including admission to a hospital or another appropriate health care facility, in such institutions and at such places as the Smith Sings Program, acting through its agents, deems best. We/I authorize the agents or employees of the Smith Sings Program to execute whatever forms might be necessary to ensure complete and adequate care of my/our child.

\_\_\_\_\_  
**Signature of student**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of legally responsible parent or guardian**

\_\_\_\_\_  
**Date**

-----

We/I understand that a Registered Nurse (RN) is available for consultation on campus, but anything beyond first aid treatment will be referred to the Emergency Room (ER).

\_\_\_\_\_  
**Signature of student**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of legally responsible parent or guardian**

\_\_\_\_\_  
**Date**

**Part II: To be filled out by student/family and signed by a medical provider:**

**RECORD OF IMMUNIZATIONS/TESTS**

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_  
\_\_\_\_\_

**REQUIRED:**

Massachusetts' law and/or Smith College require the following immunizations or tests for *all* participating students. **You will not be able to participate in Smith Sings 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 of measles, one dose each of mumps and 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

**RUBELLA** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
mm dd yy  
or date of titer \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Titer result \_\_\_\_\_ (attach copy of lab)  
mm dd yy

**MUMPS** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
mm dd yy  
or date of titer \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Titer result \_\_\_\_\_ (attach copy of lab)  
mm dd yy

Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

**REQUIRED IMMUNIZATIONS (continued):**

**MENINGOCOCCAL VACCINE** or Waiver of Vaccine: (required by the Massachusetts Department of Public Health. Information and Waiver form enclosed)

\*Quadrivalent polysaccharide vaccine (i.e. Menomune) \_\_\_\_/\_\_\_\_/\_\_\_\_  
OR mm dd yy  
\*Conjugate Vaccine (i.e. Menactra) \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm dd yy

**REQUIRED TUBERCULOSIS SCREENING:** The attached Tuberculosis Risk Questionnaire must be completed and signed by your primary care provider. If the answer to any of the risk assessment questions is "yes", Smith College requires that you have a tuberculin skin test to check for latent tuberculosis infection—see attached Medical Evaluation for College Students for Latent Tuberculosis Form.

---

**RECOMMENDED:**

**VARICELLA** (either history of disease, positive titers or two doses of vaccine given at least one month apart if immunized after age 13)

\*History of disease yes \_\_\_\_\_ no \_\_\_\_\_

\*Varicella antibody \_\_\_\_/\_\_\_\_/\_\_\_\_ reactive \_\_\_\_\_ non-reactive \_\_\_\_\_  
mm dd yy

\*Immunization Dose #1 \_\_\_\_/\_\_\_\_/\_\_\_\_, Dose #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ at least one month from first, if given  
age 13 or older mm dd yy mm dd yy

---

M.D./N.P.'s signature \_\_\_\_\_ Date \_\_\_\_\_  
(Required)

**Part III: TUBERCULOSIS SCREENING (Required)**

Name \_\_\_\_\_

\_\_\_\_\_ Last First Middle Date of Birth

**Risk Assessment Questionnaire**

- |   | Yes                            | No                             |
|---|--------------------------------|--------------------------------|
| A. To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis? | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| B. Were you born in one of the countries listed below?  | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |
| C. Have you traveled or lived for more than one month in any of the countries listed below                    | <input type="checkbox"/> _____ | <input type="checkbox"/> _____ |

**COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)\***

\*World Health Organization Global tuberculosis control. WHO report 2003.

Afghanistan	Djibouti	Latvia	Philippines
Algeria	Dominican Republic	Lesotho	Romania
Angola	Ecuador	Liberia	Russian Federation
Armenia	El Salvador	Lithuania	Rwanda
Azerbaijan	Equatorial Guinea	Madagascar	SaoTome & Principe
Bahrain	Eritea	Malawi	Senegal
Bangladesh	Estonia	Malaysia	Sierra Leone
Belarus	Ethiopia	Maldives	Solomon Islands
Benin	Gabon	Mali	Somalia
Bhutan	Gambia	Marshall Islands	South Africa
Bolivia	Georgia	Mauritania	Sri Lanka
Bosnia & Herzegovina	Ghana	Mauritius	Sudan
Botswana	Guam	Micronesia	Suriname
Brazil	Guatemala	Moldova, Republic	Swaziland
Brunei Darussalam	Guinea	Mongolia	Syrian Arab Republic
Durkina Faso	Guinea-Bissau	Morocco	Tajikistan
Burundi	Guyana	Mozambique	Tanzania, UR
Cambodia	Haiti	Myanmar	Thailand
Cameroon	Honduras	Namibia	Togo
Cape Verde	India	Nepal	Tokelau
Central African Republic	Indonesia	New Caledonia	Turkmenistan
Chad	Iran	Nicaragua	Uganda
China	Iraq	Niger	Ukraine
China, Hong Kong SAR	Kazakhstan	Nigeria	Uzbekistan
China, Macao SAR	Kenya	Northern Mariana Islands	Vanuatu
Comoros	Kiribati	Pakistan	Vietnam
Congo	Korea, DPR	Palau	Yemen
Congo, DR	Korea, Republic	Papua New Guinea	Zambia
Cote d'Ivoire	Kyrgyzstan	Paraguay	Zimbabwe
Croatia	Lao, PDR	Peru	

If the answers to the above questions are all "NO," have your doctor review and sign the form. No further action is needed.

If the answer to ANY of the above questions is "YES," you are required to have a Tuberculin Skin Test (See attached.) If you had a positive PPD in the past and you were not treated for latent or active TB, you do not need a PPD, but you are required to have a chest x-ray within the last 12 months.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

Provider Signature (verify above) \_\_\_\_\_ Date \_\_\_\_\_

# Medical Evaluation of College and University Students for Latent Tuberculosis Infection

(If the answer to any of the questions on the Risk Assessment was "yes" you are required to complete this page.)

Name \_\_\_\_\_  
\_\_\_\_\_ Last First Middle Date of Birth

## TUBERCULIN SKIN TEST

Date of testing \_\_\_\_\_ Date of result \_\_\_\_\_

Result (48-72 hours) \_\_\_\_\_ mm of duration in horizontal diameter.  
(If no induration, mark "0")

Note: Use 5 TU Mantoux test (Intermediate PPD) only; result of multiple puncture tests, such as Tine, Heaf, or Mono-vacc, not accepted. If unavailable, please defer testing until you arrive at Smith College.

## Interpretation of Tuberculin Skin Test

RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for one month or more in a country that has a high rate of tuberculosis	10 mm or more
None (test not recommended)	15 mm or more

## Risk-based interpretation

\_\_\_\_ NEGATIVE      \_\_\_\_ POSITIVE (If positive, chest x-ray prior to enrollment is required – see below)

## Chest X-ray and treatment

Chest x-ray (For newly positive PPD, a current chest x-ray is required; if PPD positive in the past but not treated for active or latent TB, a chest x-ray within the last 12 months prior to enrollment is required.)

DATE of chest x-ray: \_\_\_\_\_

\_\_\_\_ NORMAL      \_\_\_\_ ABNORMAL

Treatment (required for active tuberculosis, recommended for latent tuberculosis infections)

\_\_\_\_  YES

\_\_\_\_  NO

\_\_\_\_\_  
DRUG, DOSE, FREQUENCY, AND DATES

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_