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 to Director of Health Services, 69 Paradise Road, Northampton, MA 01063, by JUNE 11, 2010.

This information is **STRICTLY CONFIDENTIAL** and is requested so that we may provide the student with the best possible medical care.

PART I (To be completed by student)

Name _____ Date of birth _____

Birthplace _____

Smith College class of _____ Smith College ID number _____

Permanent address _____

_____

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

EMERGENCY CONTACT

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 that 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) _____

THIS QUESTIONNAIRE IS CONFIDENTIAL.

PART II (This form must be completed and signed by your health care provider based on an examination dated no earlier than August 1, 2009.)

MEDICAL EXAMINATION FORM

Student's name _____

Height _____ Weight _____ Pulse (sitting) _____ Blood pressure (sitting) _____

Circle applicable answers.

Nutrition.....(normal / over / under)
Skin .....(clear / not clear)
Eyes .....(normal / abnormal)
Vision Near Distant Near Distant
Right _____ cor. to _____
Left_____ cor. to _____
Ears .....(normal / abnormal)
Hearing .....(normal / abnormal)
Nose .....(normal / abnormal)
Throat .....(normal / abnormal)
Tonsils .....(normal / abnormal / absent / remnants)
Teeth .....(good / poor repair)
Lymph nodes .....(normal / abnormal)
Thyroid .....(normal / abnormal)
Thorax .....(normal / abnormal)

Breasts..... (normal / abnormal)
Lungs ..... (normal / abnormal)
Spine ..... (normal / abnormal)
Heart ..... (normal / abnormal)
murmurs ..... (absent / present)
rhythm ..... (normal / abnormal)
(syst/dias/presyst/click)
Abdomen..... (normal / abnormal)
Hernia ..... (absent / present)
Pelvic if performed.... (normal / abnormal)
Rectal if performed.... (normal / abnormal)
Pilonidal sinus..... (absent / present)
Extremities..... (joints/veins/skin/edema)
Upper Lower
Reflexes..... (normal / abnormal)

REQUIRED

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

If so, list.

May student participate in competitive athletic programs? ☐ **Yes** ☐ **No**

Is this student under any form of medical or psychiatric treatment and/or prescription medication? ☐ **Yes** ☐ **No**

If so, list:

Has the student ever had an eating disorder? ☐ **Yes** ☐ **No** **If yes, please explain:**

Menstrual history—Age at onset: **Usual interval between periods:**

P.A.
N.P.
D.O.
M.D.

M.D./D.O./N.P./P.A.'s Name (please print) Signature

May *not* be signed by a family member

Address

Date of Exam Telephone number ( )

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

RECORD OF IMMUNIZATIONS/TESTS

Name _____
Last First MI 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 M.D., D.O., N.P. or P.A.**

TETANUS/DIPHTHERIA

Completed primary series of four doses (DTaP or DTP) ☐ No ☐ Yes Date completed ___/___/___ (mm dd yy)

***Td or Tdap** booster **(circle which vaccine used)**—within the last 10 years ___/___/___ (mm dd yy)

POLIO

Primary series of four doses (OPV/IPV or combination—last dose after age 4) ☐ No ☐ Yes Date completed ___/___/___ (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 ___/___/___ or date of titer ___/___/___ Titer result _____(attach copy of lab report)

OR

MEASLES first dose ___/___/___ second dose ___/___/___ or date of titer ___/___/___ Titer result _____(attach copy of lab report)

MUMPS first dose ___/___/___ second dose ___/___/___ or date of titer ___/___/___ Titer result _____(attach copy of lab report)

RUBELLA first dose ___/___/___ or date of titer ___/___/___ Titer result _____(attach copy of lab report)

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

Date ___/___/___, ___/___/___, ___/___/___, dosage _____mcg or ANTHBS: date ___/___/___
Titer result _____(attach copy of lab report)

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

Menactra (conjugate vaccine) ___/___/___ **OR** **Menomune** (quadrivalent polysaccharide vaccine) ___/___/___ (within the past 5 years)

VARICELLA (History of chicken pox disease, or positive varicella antibody, or vaccination meets the requirement)

History of disease: ☐ Yes (age or date) _____ ☐ No

Varicella antibody ___/___/___ reactive _____ non-reactive _____ (attach copy of lab report)

Immunization first dose ___/___/___, second dose ___/___/___ (age 7–12 minimum interval three months between doses; age 13 and older minimum interval between doses is four weeks)

PART IV TUBERCULOSIS SCREENING (Required)

TUBERCULOSIS RISK QUESTIONAIRE

Name

Last First MI Date of Birth

Please answer the following:

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 5 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

**future CDC updates may eliminate the 5 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	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Swaziland
Argentina	Dominican Republic	Kuwait	Niue	Syrian Arab Republic
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 & the Grenadines	Uzbekistan
Burkina Faso	Guinea	Mexico	São Tomé & Príncipe	Vanuatu
Burundi	Guinea-Bissau	Micronesia	Saudi Arabia	Venezuela
Cambodia	Guyana	Moldova-Rep.	Senegal	Viet Nam
Cameroon	Haiti	Mongolia	Seychelles	Wallis & Futuna Islands
Cape Verde	Honduras	Montenegro	Sierra Leone	West Bank & Gaza Strip
Central African Rep.	India	Morocco	Singapore	Yemen
Chad	Indonesia	Mozambique	Solomon Islands	Zambia
China	Iran	Myanmar	Somalia	Zimbabwe
Colombia	Iraq	Namibia	South Africa	
Comoros	Japan	Nauru	Spain	
Congo	Kazakhstan	Nepal		

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 Medical Evaluation Form for Tuberculosis (see next page) must be completed. You are required to have a Tuberculin Skin Test/PPD (TST) or Interferon Gamma Release Assay (IGRA) **within 3 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
May *not* be signed by a family member

TUBERCULOSIS (TB) MEDICAL EVALUATION

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

Name _____
Last First MI Date of Birth

1. Does the student have signs or symptoms of active tuberculosis disease? ☐ **Yes** ☐ **No**

If **No**, proceed to 2a **or** 2b below.

If **Yes**, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2a. Tuberculin Skin Test/PPD (TST)—The TST interpretation is based on mm of induration as well as risk factors.**

Date given ___/___/___ Date read ___/___/___ Result _____mm of induration, transverse diameter
mm dd yy mm dd yy (If no induration, mark "0")

**Interpretation: positive_____ negative_____

****Interpretation of Tuberculin Skin Test guidelines**

Risk Factor	Positive Result
Close contact with an individual with Infectious TB	**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**

OR

2b. Interferon Gamma Release Assay (IGRA)—Attach copy of lab result

Date obtained ___/___/___ (specify method) QFT-G_____QFT-GIT_____other_____ Result: Negative____ Positive____
mm dd yy Intermediate____

3. Chest x-ray: (Required within the last 3 months prior to enrollment in classes, if TST or IGRA is positive)

Date of chest x-ray ___/___/___ Result: normal_____ abnormal_____
mm dd yy

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

☐ **Yes** _____
DRUG, DOSE, FREQUENCY AND DATES

☐ **No**

M.D./D.O./N.P./P.A. signature **Date**

(Required—May *not* be signed by a family member)

Name

Last First MI Date of Birth

Optional Vaccines (Please list clearly other immunizations you have received.)

HPV Vaccine ___/___/___ , ___/___/___ , ___/___/___ indefinite immunity
mm dd yy

Hepatitis A ___/___/___ booster dose 6–12 months later ___/___/___ indefinite immunity
mm dd yy

IPV (one time adult booster dose) ___/___/___ indefinite immunity
mm dd yy

Typhoid Typhim VI polysaccharide vaccine (injectable) ___/___/___ protective for two years
mm dd yy

OR

Vivotif (oral vaccine) ___/___ protective for five years
mm yy

Yellow Fever ___/___/___ protective for 10 years
mm dd yy

Japenese Encephalitis Vaccine **Je-Vax** ___/___/___ , ___/___/___ , ___/___/___ protective for two to three years
mm dd yy

OR

IXIARO ___/___/___ , ___/___/___ unknown duration of protection
mm dd yy

M.D./D.O./N.P./P.A. signature **Date**

(Required—May *not* be signed by a family member)

Revised 1/6/04, 10/26/04, 11/22/04, 12/1/05, 12/4/06, 10/24/08, 1/15/10 eml