HEALTH FORM REQUIREMENTS CHECK LIST

You must fill in all of the following information on your Health Form.
Incomplete forms will be returned for completion. You will not be able to register for classes until your Health Form is complete.

Before mailing the enclosed documents, please make sure you have completed the following:

☐ Smith student ID number

☐ Signature of student (Part I)

☐ Signature of parent or guardian (Part I) for all undergraduate students regardless of age—with the exception of Ada Comstock Scholars

☐ All dates are in month/day/year format.

☐ All pages requiring signatures have been signed and dated.

☐ Your physical exam was after August 1, 2014 (Part II).

☐ Your clinician has answered all the questions on the lower half of the Physical Examination form (Part II).

☐ Your clinician has completed, signed and dated the following:
  Part II—Physical Examination
  Part III—Immunizations/Tests
  Part IV—Tuberculosis Screening including the Tuberculosis Medical Evaluation (if you answered yes to any of the questions in Part IV)

☐ Copies of all lab test reports (immune titers and/or IGRA) if they were done to complete the immunization requirement and/or Tuberculosis (TB) Medical Evaluation.

If you have any questions about the Health Form, please contact healthservices@smith.edu.

If you are requesting any type of accommodation, including for food, housing and academics, please communicate directly with Laura Rauscher, Director, Office of Disability Services, lrausche@smith.edu or 413-585-2071.
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, 21 Belmont Avenue, Northampton, MA 01063, by JUNE 1, 2015.

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 participant and parent/guardian

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
<tr>
<td>Birthplace</td>
<td></td>
</tr>
</tbody>
</table>

Smith College class of _______ Smith College ID number _______

Permanent address ____________________________________________________________

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

FAMILY HISTORY—Check if condition exists in your immediate biological family (parents, siblings, grandparents, aunts, uncles)

Cancer_____ Diabetes_____ Heart Disease_____ High Blood Pressure_____ Kidney Disease/Stones_____

Asthma/Lung Disease____ Family history of sudden death before age 50 ___

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 give permission for the aforementioned student to receive general, non-surgical medical treatment and diagnosis, including, but not limited to, immunizations, from Smith College Health Services or such other health care provider as Smith College Health Services shall determine to be medically necessary or desirable for the student. In the event a medical emergency arises and the emergency contact(s) identified above cannot be reached, I hereby give permission for the Director of Smith College Health Services, or his or her designee, to make treatment decisions for the aforementioned student, including, but not limited to, emergency care and hospitalization, if deemed necessary at the discretion of Smith College Health Services in order to avoid delay which might jeopardize the life or recovery of the aforementioned student.

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, 2014.)

MEDICAL EXAMINATION FORM

Student's name

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Pulse (sitting)</th>
<th>Blood pressure (sitting)</th>
</tr>
</thead>
</table>

Circle applicable answers.

Nutrition ................. (normal / over / under)  Heart ..................... (normal / abnormal)
Skin .......................... (clear / not clear)  murmurs ........ (absent / present)
Eyes .......................... (normal / abnormal)  Thorax ..................... (normal / abnormal)
Ears .......................... (normal / abnormal)  Lungs ....................... (normal / abnormal)
Hearing ..................... (normal / abnormal)  Breasts ..................... (normal / abnormal / not examined)
Nose .......................... (normal / abnormal)  Abdomen .................... (normal / abnormal)
Throat ....................... (normal / abnormal)  Spine .......................... (normal / abnormal)
Tonsils ....................... (normal / abnormal / absent / remnants)  Pelvic ....................... (normal / abnormal / not performed)
Thyroid ...................... (normal / abnormal)  Extremities .................. (normal / abnormal)
Lymph nodes .................. (normal / abnormal)  Reflexes ..................... (normal / abnormal)

REQUIRED

Does student have any allergies to medications and/or foods?  □ Yes  □ No

If so, list.

Please give details/dates of any significant hospitalization/surgeries, injuries with loss of consciousness:

May student participate in competitive athletic programs?  □ Yes  □ No

Is this student under any form of medical or psychiatric care?  □ Yes  □ No

If so, please explain:

Does this student have any chronic or congenital conditions?  □ Yes  □ No

If so, please explain:

Is this student taking any prescription medications?  □ Yes  □ No

If so, please list:

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

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 (    )

Month / Day / Year
PART III  REQUIRED RECORD OF IMMUNIZATIONS/TESTS

Name _______________________________________

Massachusetts’s 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 an M.D., N.P., D.O., P.A.

**Tetanus-Diphtheria-Pertussis**
Completed primary series (date of final dose of DTP/DTaP)

**AND**
Tdap booster required within the past 10 years

Unless Td booster within last 5 years

**Do not use Td to update vaccination if Tdap has never been administered. Tdap will be available through Health Services.**

**Polio**
Completed primary series four doses (OPV/IPV or combination—last dose after age 4)

**Measles, Mumps, Rubella (MMR)**—born before 1957 can be considered immune

**Combined MMR—2 doses required:**
Dose 1 given on or after 12 months of age
Dose 2 given at least four weeks after first dose

OR
Serologic Titers *(Must provide copy of lab report)*

Measles (Rubella)  □ Immune  □ Not Immune

Mumps  □ Immune  □ Not Immune

Rubella  □ Immune  □ Not Immune

**Varicella**—born in the U.S. before 1980 can be considered immune

**Varicella—2 doses required**
Dose 1 given on or after 12 months of age
Dose 2 given at least four weeks after first dose

OR
Serologic Titers *(Must provide copy of lab report)*

Varicella  □ Immune  □ Not Immune

OR
History of Chickenpox disease

**Hepatitis B**

**Hepatitis B—3 doses required**
Dose 1 given at any time after birth
Dose 2 given at least four weeks after first dose
Dose 3 given six months after dose 1 and a minimum of eight weeks after dose 2

*If two-adult-dose alternate series given—must include dose and manufacturer name*

OR
Serologic Titers for Hepatitis B Surface Antibody *(Must provide copy of lab report)*

**Meningococcal Vaccine**

MCV4—conjugate vaccine (Menactra or Menveo)
(MTwo doses recommended if dose 1 given before age 16)

OR
MPSV4—polysaccharide vaccine (Menomune or Mencevax) within the past five years

Document the following vaccines if you have received:

<table>
<thead>
<tr>
<th>Other Immunizations</th>
<th>Date Dose #1</th>
<th>Date Dose #2</th>
<th>Date Dose #3</th>
<th>Date Dose #4 or Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis B - Trumenba</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningitis B - Bexsero</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
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<tr>
<td>HPV*</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Typhoid (injectable)—most recent</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Typhoid (oral)—most recent completed</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Japanese Encephalitis (Ixiaro)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td></td>
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<tr>
<td>Rabies</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Other (i.e., Flu)</td>
<td></td>
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</tr>
</tbody>
</table>

*HPV vaccine is recommended for all students

M.D./D.O./N.P./P.A. Signature  (Required—May not be signed by a family member)

Date  Month / Day / Year
TUBERCULOSIS RISK QUESTIONNAIRE

Name  Last  First  MI  Date of Birth

Please answer the following:

Have you ever had a positive tuberculosis (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 will you be arriving or did you arrive in the U.S. within the past five years?* (If yes, please CIRCLE the country.)  □ Yes  □ No

Have you ever traveled** for more than two weeks to/in one or more of the countries listed below? (If yes, please CHECK the country/ies and list dates of travel.)  □ 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  Comoros  Iran  Mozambique  Somalia
Algeria  Congo (Democratic Republic)  Kazakhstan  Myanmar  South Africa
Angola  Congo (Republic)  Kenya  Nepal  South Sudan
Anguilla  Djibouti  Kiribati  Nauru  Sri Lanka
Argentina  Côte d’Ivoire  Korea, DPR  Nepal  Sudan
Armenia  Dominican Republic  Korea, Republic of  Nicaragua  Suriname
Azerbaijan  Ecuador  Kuwait  Niger  Swaziland
Bangladesh  El Salvador  Kyrgyzstan  Nigeria  Tajikistan
Belarus  Equatorial Guinea  Laos (People’s Democratic Republic)  Northern Mariana Islands  Thailand
Belize  Eritrea  Latvia  Pakistan  Timor-Leste
Benin  Estonia  Lesotho  Palau  Togo
Bhutan  Ethiopia  Liberia  Panama  Papua New Guinea
Bolivia  Fiji  Libya  Paraguay  Trinidad and Tobago
Bosnia and Herzegovina  French Polynesia  Lao PDR  Peru  Turkey
Botswana  Gabon  Madagascar  Philippines  Turkmenistan
Brazil  Georgia  Malawi  Poland  Tuvalu
Brunei Darussalam  Ghana  Malaysia  Portugal  Uganda
Bulgaria  Georgia  Maldives  Qatar  Ukraine
Burkina Faso  Greenland  Mali  Romania  Uruguay
Burundi  Guam  Marshall Island  Russian Federation  Uzbekistan
Cabo Verde  Guatemala  Mauritania  Rwanda  Vanuatu
Cambodia  Guinea  Mauritius  Saint Vincent and the Grenadines  Venezuela (Bolivarian Republic)
Cameroon  Guinea-Bissau  Mexico  São Tomé & Príncipe  Vietnam
Central African Republic  Guyana  Micronesia (Federated States of)  Senegal  Yemen
Chad  Haiti  Moldova, Republic of  Seychelles  Zambia
China  Honduras  Mongolia  Sierra Leone  Zimbabwe
China, Hong Kong SAR  India  Montenegro  Singapore
China, Macao SAR  Indonesia  Morocco  Solomon Islands
Colombia  Iran (Islamic Rep. of)  Rep.

Source: World Health Organization, Global Tuberculosis Report 2013. Countries with Tuberculosis incidence rates of ≥20 cases per 100,000 population.

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 three months prior to enrollment in classes, unless a previous positive skin test or IGRA 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 (Month / Day / Year)  M.D./D.O./N.P./P.A. Signature  Required Date (Month / Day / Year)
May not be signed by a family member
TUBERCULOSIS (TB) MEDICAL EVALUATION

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
</tr>
</tbody>
</table>

1. Does the student have signs or symptoms of active tuberculosis disease?  Yes_____ * No_____  
   
If Yes, see * at the bottom of this page.  
If No, proceed to 2a (IGRA blood test) or 2b (ppd skin test). We prefer IGRA testing to ppd testing. If IGRA testing not available, ppd skin test is required unless already has a positive skin test on file—proceed to number 3.  

2a. Interferon Gamma Release Assay (IGRA)—required if history of prior “positive” skin test or if current skin test is interpreted as “positive.” Attach copy of lab result—If testing unavailable, it will be done at Health Services upon arrival.  
   
Date obtained ___ /___ /___ (specify method)  
   QFT-GIT: Result: Negative___ Positive___ Intermediate___  
   TSpot.TB test: Result: Negative___ Positive___ Borderline___  

2b. Tuberculin Skin Test/PPD (TST)—if no history of prior positive skin test and IGRA testing not available.  
   
Date given ___ /___ /___ Date read ___ /___ /___  
   Result:____ mm of induration, transverse diameter  
   (If no induration, mark “0”)  
   Interpretation: positive____ negative____  
   **Interpretation of Tuberculin Skin Test guidelines  
   **

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Positive Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Close contact with an individual with infectious tuberculosis</td>
<td>5 mm or more</td>
</tr>
<tr>
<td>Born in a country that has a high rate of tuberculosis</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>Traveled or lived for one month or more in a country that has a high rate of tuberculosis</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>None (test not recommended)</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

3. Chest x-ray: (Required if IGRA is positive OR if skin test is positive). Must be dated within the last three months prior to enrollment in classes.)  
   
Date of chest x-ray ___ /___ /___  
   Result: normal____ abnormal_____  

Please note:  
Students who reside outside the United States, in one of the countries listed on the previous page, will be required to have TSpot.TB testing upon arrival at Smith College, if IGRA documentation has not been submitted.  

M.D./D.O./N.P./P.A. signature | Date  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(Required—May not be signed by a family member)</td>
<td>Month / Day / Year</td>
</tr>
</tbody>
</table>

*Students with either a history of or current diagnosis of active tuberculosis must provide a letter from a Tuberculosis Specialist documenting that the student is no longer infectious. Documentation must include medication(s)—dose, frequency, duration, date treatment completed and lab copies of all sputum results. In addition to providing Health Services with this documentation, anyone currently being treated for active tuberculosis will be required to meet with the Medical Director upon arrival. Anyone currently being treated for active tuberculosis without documentation will not be allowed to travel to campus.