



SMITH COLLEGE

Schacht Center for
Health and Wellness

www.smith.edu/health

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
- Student name and date of birth must be filled in on each page of form
- 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, 2016 (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 any of the immunization requirements 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.



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Full clearance for registration will not be granted until all pre-entrance medical requirements have been met. Please return this completed form to Schacht Center for Health and Wellness, 21 Belmont Avenue, Northampton, MA 01063, by JUNE 1, 2017.

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

Name Last First Date of birth Month / Day / Year

Birthplace

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, nonsurgical medical treatment and diagnosis, including, but not limited to, immunizations, from the Schacht Center for Health and Wellness or such other health care provider as the Schacht Center for Health and Wellness 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 the Schacht Center for Health and Wellness, 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 the Schacht Center for Health and Wellness in order to avoid delay that 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, 2016.)

MEDICAL EXAMINATION FORM

Student's name _____ Smith ID # _____

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

Circle applicable answers.

- | | |
|---|--|
| Skin (clear / not clear) | Heart (normal / abnormal) |
| Eyes (normal / abnormal) | murmurs (absent / present) |
| Ears (normal / abnormal) | Thorax (normal / abnormal) |
| Hearing (normal / abnormal) | Lungs (normal / abnormal) |
| Nose (normal / abnormal) | Breasts (normal / abnormal / not examined) |
| Throat (normal / abnormal) | Abdomen (normal / abnormal) |
| Tonsils (normal / abnormal / absent / remnants) | Spine (normal / abnormal) |
| Thyroid (normal / abnormal) | Pelvic (normal / abnormal / not performed) |
| Lymph nodes (normal / abnormal) | Extremities (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:

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

If so, please list:

Is this student receiving more than routine medical care? Yes No

If so, please explain:

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

If so, please explain:

Is this student taking any prescription medications? Yes No

If so, please list:

Has this student had any significant weight changes in the past year? Yes No If yes, please explain:

Is this student planning on participating in an intercollegiate sport? Yes No
If yes, the enclosed preparticipation sport examination form must be completed before participation will be allowed.

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

Address _____ *May not be signed by a family member*

Date of Exam _____ Telephone number () _____

Month / Day / Year

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

PART III REQUIRED RECORD OF IMMUNIZATIONS/TESTS

Name _____
 Last First Date of Birth

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.**

Document Dates as Month/Day/Year

Tetanus-Diphtheria-Pertussis

Completed childhood primary series (date of final dose of DTP/DTaP) Date completed _____
AND
Tdap booster (Adacel or Boostrix) required within the past 10 years Tdap _____
 Unless Td booster within last 5 years Td _____

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

Polio

Completed childhood primary series four doses (OPV/IPV or combination— **last dose after age 4**) Date completed _____

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 MMR #1 _____
 Dose 2 given at least four weeks after first dose MMR #2 _____
OR
Serologic Titers (Must provide copy of lab report)
 Measles (Rubeola) Immune Not Immune Date: _____
 Mumps Immune Not Immune Date: _____
 Rubella Immune Not Immune Date: _____

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 Varicella #1 _____
 Dose 2 given at least four weeks after first dose Varicella #2 _____
OR
Serologic Titers (Must provide copy of lab report)
 Varicella Immune Not Immune Date: _____
OR
 History of Chickenpox disease Date: _____

Hepatitis B

Hepatitis B—3 doses required
 Dose 1 given at any time after birth Hep B #1 _____
 Dose 2 given at least four weeks after first dose Hep B #2 _____
 Dose 3 given six months after dose 1 and a minimum of eight weeks after dose 2 Hep B #3 _____
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)
 Hepatitis B Immune Not Immune Date: _____

Meningococcal Vaccine

MCV4—conjugate vaccine (Menactra or Menveo) MCV4 #1 _____
 (Two doses recommended if dose 1 given before age 16) MCV4 #2 _____
OR
 MPSV4—polysaccharide vaccine (Menomune or Mencevax) within the past five years MPSV4 _____

Document the following vaccines if you have received:

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

*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

PART IV TUBERCULOSIS SCREENING (Required)

TUBERCULOSIS RISK QUESTIONNAIRE

Name			Date of Birth	
Last	First	MI	Month	Day/Year

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	Kiribati	Nauru	Suriname
Algeria	Congo (Republic)	Korea, DPR	Nepal	Swaziland
Angola	Congo (Democratic Republic)	Korea, Republic of	New Caledonia	Syrian Arab Republic
Anguilla		Kuwait	Nicaragua	Tajikistan
Argentina	Côte d'Ivoire	Kyrgyzstan	Niger	Tanzania, United Rep. of
Armenia	Djibouti	Laos (People's Democratic Republic)	Nigeria	Thailand
Azerbaijan	Dominican Republic		Northern Mariana Islands	Timor-Leste
Bangladesh	Ecuador	Latvia	Pakistan	Togo
Belarus	El Salvador	Lesotho	Palau	Tunisia
Belize	Equatorial Guinea	Liberia	Panama	Turkmenistan
Benin	Eritrea	Libya	Papua New Guinea	Tuvalu
Bhutan	Ethiopia	Lithuania	Paraguay	Uganda
Bolivia	Fiji	Madagascar	Peru	Ukraine
(Plurinational State of)	Gabon	Malawi	Philippines	Uruguay
Bosnia and Herzegovina	Gambia	Malaysia	Portugal	Uzbekistan
Botswana	Georgia	Maldives	Qatar	Vanuatu
Brazil	Ghana	Mali	Romania	Venezuela (Bolivarian Republic of)
Brunei Darussalam	Greenland	Marshall Island	Russian Federation	
Bulgaria	Guam	Mauritania	Rwanda	Vietnam
Burkina Faso	Guatemala	Mauritius	São Tomé & Príncipe	Yemen
Burundi	Guinea	Mexico	Senegal	Zambia
Cabo Verde	Guinea-Bissau	Micronesia (Federated States of)	Serbia	Zimbabwe
Cambodia	Guyana		Sierra Leone	
Cameroon	Haiti	Moldova, Republic of	Singapore	
Central African Republic	Honduras	Mongolia	Solomon Islands	
Chad	India	Montenegro	Somalia	
China	Indonesia	Morocco	South Africa	
China, Hong Kong SAR	Iraq	Mozambique	South Sudan	
China, Macau SAR	Kazakhstan	Myanmar	Sri Lanka	
Colombia	Kenya	Namibia	Sudan	

Source: World Health Organization, Global Tuberculosis Report 2015. 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 an Interferon Gamma Release Assay (IGRA) or a Tuberculin Skin Test/PPD (TST) **dated no earlier than May 1, 2017**. If a previous positive IGRA or positive skin test has been documented a chest x-ray will be required before arrival on campus.

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.)

Name _____ Date of Birth _____
Last First MI Month/Day/Year

1. Does the student have signs or symptoms of active tuberculosis disease?

Yes _____, see * at the bottom of this page.

No _____, proceed to 2a (IGRA blood test) **If IGRA testing not available, ppd skin test (2b) is required unless patient has a positive skin test on file. A chest X-ray is required for all positive test results—see 3.**

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.

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 is unavailable, it will be done at the Schacht Center for Health and Wellness upon arrival. Must be dated no earlier than May 1, 2017.

Date obtained ____/____/____ (specify method) QFT-GIT: Result: Negative____ Positive____ Intermediate____
mm dd yy 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. Must be dated no earlier than May 1, 2017.

Date given ____/____/____ Date read ____/____/____ **Result:** ____mm of induration, transverse diameter
mm dd yy mm dd yy (If no induration, mark “0”)

Interpretation: positive____ negative____**
 The TST interpretation is based on mm of induration as well as risk factors.**

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

Risk Factor	Positive Result
Close contact with an individual with infectious 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

3. Chest x-ray: (Required if IGRA is positive OR if skin test is positive). Must be dated no earlier than May 1, 2017.

Date of chest x-ray ____/____/____ Result: normal____ abnormal____
mm dd yy

M.D./D.O./N.P./P.A. signature _____ **Date** _____
(Required—May not be signed by a family member) Month / Day / Year

*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 the Schacht Center for Health and Wellness with this documentation, anyone currently being treated for active tuberculosis will be required to meet with the College Physician upon arrival. Anyone currently being treated for active tuberculosis without documentation will not be allowed to travel to campus.