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 _____ Date of birth _____
Last First 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)
Eyes .....(normal / abnormal)
Ears .....(normal / abnormal)
Hearing .....(normal / abnormal)
Nose .....(normal / abnormal)
Throat .....(normal / abnormal)
Tonsils .....(normal / abnormal / absent / remnants)
Thyroid .....(normal / abnormal)
Lymph nodes .....(normal / abnormal)

Heart ..... (normal / abnormal)
murmurs ..... (absent / present)
Thorax..... (normal / abnormal)
Lungs ..... (normal / abnormal)
Breasts..... (normal / abnormal / not examined)
Abdomen..... (normal / abnormal)
Spine ..... (normal / abnormal)
Pelvic..... (normal / abnormal / not performed)
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.

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 ( )

Month / Day / Year

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 **Date**

(Required—May *not* be signed by a family member) Month / Day / Year

PART IV TUBERCULOSIS SCREENING (Required)

TUBERCULOSIS RISK QUESTIONAIRE

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

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.