HEALTH FORM REQUIREMENTS CHECK LIST

Complete all pages and return to Health Services by June 1, 2018.

Clearance for registration will not be granted until all pre-entrance medical requirements have been met. A HOLD will be placed on your account until all required information is received.

Part 1: Student Information and Financial Responsibility

☐ Emergency Contact information must be complete. If the student is under 18, the first contact must be a parent or guardian. All emergency contacts must be over 18 and capable of making emergency medical decisions.

☐ Signatures of student and of parent or guardian for all undergraduate students regardless of age.
    (Exception: Ada Comstock Scholars do not need parent/guardian signature.)

Part 2: Medical Examination: completed and signed by your health care provider.

☐ Allergies:
    Students with severe allergies are encouraged to carry an epinephrine device at all times.
    Students with food allergies are encouraged to register with the Office of Disability Services.
    We do not provide allergy shots: please contact our office or refer to our website for further information.

☐ Physical Exam must be performed no earlier than August 1, 2017, and signed by the healthcare provider.

☐ Sports pre-participation Physical Form is completed if student intends to play intercollegiate sports.

Immunizations/Tests: See Welcome To Smith student letter

☐ Include copies of any/all titer blood test results and dates.
    Required immunizations can be obtained at most large retail pharmacies.

Part 3: TUBERCULOSIS SCREENING: Required of all students.

☐ Tuberculosis Medical Examination is also required for any YES answers on screening (Part 3A).

☐ Include PPD; IGRA TB blood test; and/or chest X-ray dates and copies of results if they were done.

If you are requesting any type of accommodation, including for food allergy, housing and academics, please communicate directly with Laura Rauscher, Director, Office of Disability Services,
Irausche@smith.edu or 413-585-2071.

Students with food allergies are encouraged to review dining services options.

PLEASE RETURN THIS COMPLETED FORM TO THE SCHACHT CENTER FOR HEALTH AND WELLNESS,
21 BELMONT AVENUE, NORTHAMPTON, MA 01063, BY JUNE 1, 2018.

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

www.smith.edu/health

Schacht Center for Health and Wellness and Pelham Medical Services
21 Belmont Avenue, Northampton Massachusetts 01063
Phone 413-585-2250  Fax 413-585-4639

1
Part 1: Student Information

Name

Last

First

Date of Birth

Month / Day / Year

Birthplace

Smith College class of

Smith College ID number

Student telephone

Student email

Permanent home address (Parent/Guardian)

Home telephone number

Home email

Part 1a: Parent/Guardian Information

1. Name

Address

Telephone number

Cell phone

Email

2. Name

Address

Telephone number

Cell phone

Email

Part 1b: Emergency Contact

Names of individual(s) over 18 to be contacted in an emergency and who is able to make medical 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

Cell Phone

Other telephone number

Email

2. Relationship to student

Address

Cell phone

Other telephone number

Email

Part 1c: 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 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 the Schacht Center for Health and Wellness 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)
Last Name ___________________________ First Name ___________________________ Date of Birth ___________________________

All information in this health form is strictly confidential

PART 2: MEDICAL EXAMINATION

Exam must be performed no earlier than August 1, 2017.*

To be completed and signed by the healthcare provider. NO portion of this form may be completed by student family member.

PAST MEDICAL HISTORY: □ No known significant Medical History

Check and provide dates and details below:

☐ Hospitalization  ☐ Surgery  ☐ Fractures  ☐ Abnormal Pap Smear  ☐ ADD or ADHD  ☐ Anemia  ☐ Anxiety

☐ Alcohol or Drug Abuse  ☐ Asthma Bronchitis/Pneumonia/Lungs  ☐ Bipolar Disorder  ☐ Blood Clot or Pneumonitis  ☐ Bowel Disease  ☐ Cancer  ☐ Depression

☐ Diabetes  ☐ Ears or Hearing  ☐ Eyes or Vision  ☐ Eating Disorder  ☐ Emotional or Mood Changes  ☐ Heart Disease  ☐ Heart Murmur

☐ Head Injury or Concussion  ☐ High Blood Pressure  ☐ Immune System  ☐ Kidney Stones or Disease  ☐ Learning Differences  ☐ Liver or Hepatitis  ☐ Tuberculosis

☐ Metabolic/Endocrine  ☐ Migraine or Other Headaches  ☐ Mononucleosis  ☐ Orthopedic or Bones  ☐ Reproductive System/Menstruation  ☐ Other  ☐ Other

☐ Weight Change  ☐ Fainting or Loss of Consciousness  ☐ Urinary Tract Infections  ☐ Other

PHYSICAL EXAM: Height _______ Weight _______ BMI ____________

BP _______ HR _______ RR _______

ALLERGIES: □ No Known Allergies  □ Medications

☐ Food  ☐ Bites  If Yes: List below and describe reaction.

MEDICATION: Does the student use any medications (Including inhalers, hormones, or contraception)

☐ YES  ☐ NO

If YES: List names of medication, dose, and reason for use.

FAMILY HISTORY: Has anyone in immediate family had:

☐ Sudden death before age 50  ☐ Heart Attack  ☐ Blood Clot  ☐ Heart Disease  ☐ High Blood Pressure  ☐ Diabetes  ☐ Cancer  ☐ Asthma  ☐ Lung Disease  ☐ Kidney Stone

ATHLETICS EXAMINATION:

Is Student participating in an intercollegiate sport?

☐ YES  ☐ NO

If YES: Complete the enclosed Preparticipation Sports Exam

DESCRIBE ABOVE:

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Signature ___________________________    M.D./D.O./N.P./P.A. ___________________________    Date: ___________________________

Signature of Healthcare Provider REQUIRED. May not be signed by student or family member.

Name of provider ___________________________    Telephone (_____)    Fax (_____)    Address ___________________________

City/Town ___________________________    State/County/Region ___________________________    Country ___________________________
PART 2B: REQUIRED RECORD OF IMMUNIZATIONS/TESTS
Massachusetts’s law and/or Smith College require the following immunizations or tests for all entering students.

This form must be signed and dated by an M.D., N.P., D.O., P.A.
Failure to meet all requirements by June 15th will result in a hold on all student accounts.

Most U.S. retail pharmacies and walk in or urgent care clinics can provide and administer vaccines. Contact your insurance provider and/or primary care provider for assistance receiving vaccines.

Vaccine locator tools such as VaccineFinder can be found at Vaccines.gov. www.vaccines.gov/more_info/features/healthmapvaccinefinder.html

<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS:</th>
<th>Date Dose 1</th>
<th>Date Dose 2</th>
<th>Date Dose 3</th>
<th>Date Dose 4</th>
<th>TITER Date and Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tdap (Adacel / Boostrix)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td>1 dose within 10 years</td>
<td></td>
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<tr>
<td>Hepatitis B</td>
<td></td>
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<tr>
<td>3 doses (0, 1 mo, 4-6mo)</td>
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<tr>
<td>or Positive Titer</td>
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<tr>
<td>Meningitis</td>
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<td>N/A</td>
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<tr>
<td>(MCV4 Menactra / Menveo)</td>
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<tr>
<td>1 dose after age 16 or within the past 5 years</td>
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<tr>
<td>Measles Mumps Rubella/MMR</td>
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<tr>
<td>2 doses of each or 2 doses combined MMR vaccine</td>
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<tr>
<td>1st dose after 12 mos of age</td>
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<tr>
<td>2nd dose at least 28 days after dose 1</td>
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<tr>
<td>3 doses of MMR are recommended for the best protection against mumps. or positive titers to each</td>
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<tr>
<td>Varicella (Chicken Pox)</td>
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<tr>
<td>2 doses required.</td>
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<tr>
<td>1st dose after 12 mos of age.</td>
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<td>2nd dose at least 28 days after dose 1.</td>
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<tr>
<td>or positive titer</td>
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<tr>
<td>Meningitis B</td>
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<td>N/A</td>
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<tr>
<td>2 doses of Bexsero brand OR</td>
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<tr>
<td>2 or 3 doses of Trumenba brand</td>
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<td>Specify brand</td>
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<tr>
<td>Recommended Immunizations</td>
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<td>Polio</td>
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<tr>
<td>primary series completed before age 4</td>
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<td>DTP</td>
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<td>N/A</td>
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<tr>
<td>primary series</td>
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<tr>
<td>Hepatitis A</td>
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<td>N/A</td>
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<td>HPV</td>
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<td>HPV</td>
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<td>N/A</td>
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<tr>
<td>Other Immunizations</td>
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<tr>
<td>Typhoid (injectable)—most recent</td>
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<tr>
<td>Typhoid (oral)—most recent completed</td>
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<tr>
<td>Japanese Encephalitis (Ixiaro)</td>
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<tr>
<td>Yellow Fever</td>
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<td>Rabies</td>
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<tr>
<td>Other (i.e., flu)</td>
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</tbody>
</table>

Signature of healthcare provider REQUIRED. May not be signed by student or family member

<table>
<thead>
<tr>
<th>Signature</th>
<th>M.D./D.O./N.P./P.A.</th>
<th>Date</th>
</tr>
</thead>
</table>

Name of provider
Telephone ( ) Fax ( )

Address

City/Town State/County/Region Country
**PART 3: TUBERCULOSIS (TB) RISK SCREENING (Required for ALL Students)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Last</th>
<th>First</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Month/Day/Year</th>
</tr>
</thead>
</table>

*If the answer to any question below is YES, the Medical Evaluation Form for Tuberculosis (Part 3A) must be completed.*

1. Have you ever had a positive tuberculosis (TB) skin test? ☐ Yes ☐ No

2. Have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No

3. Were you born in one of the countries listed below? ☐ Yes ☐ No

4. Did you arrive, or will you be arriving in the U.S. within the past five years? ☐ Yes ☐ No

5. Have you traveled for more than two weeks to/in any country/ies listed below? ☐ Yes ☐ No

Please CIRCLE the country in which you were born.
Please CIRCLE any of the countries you traveled in or to within the past 5 years. Mark with a T for travel and include dates.

- Angola
- Azerbaijan
- Belarus
- Botswana
- Brazil
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- Hong Kong
- Korea (Republic)
- Kyrgyzstan
- Lesotho
- Liberia
- Republic of Moldova
- Mozambique
- India
- Indonesia
- Namibia
- Tajikistan
- Kenya
- DPR Korea
- Peru
- Russian Federation
- South Africa
- Tanzania
- Thailand
- Uganda
- Ukraine
- Vietnam
- Zambia
- Zimbabwe
- Angola
- Azerbaijan
- Belarus
- Botswana
- Brazil
- Cambodia
- Cameroon
- Central African Republic
- Chad
- China
- Hong Kong
- Korea (Republic)
- Kyrgyzstan
- Lesotho
- Liberia
- Republic of Moldova
- Mozambique
- India
- Indonesia
- Namibia
- Tajikistan
- Kenya
- DPR Korea
- Peru
- Russian Federation
- South Africa
- Tanzania
- Thailand
- Uganda
- Ukraine
- Vietnam
- Zambia
- Zimbabwe


If the answer to all of the above questions is **NO**, no further testing or further action is required.

*If the answer to ANY question above is YES:*

☐ The Medical Evaluation Form for Tuberculosis (Part 3A) must be completed.

☐ You are required to have an Interferon Gamma Release Assay (IGRA) or a Tuberculin Skin Test/PPD (TST).

☐ This must be dated no earlier than May 1, 2018. If testing is not available, we will complete it upon arrival.

☐ A CHEST X-RAY is REQUIRED before arrival on campus for any positive IGRA or skin tests.

<table>
<thead>
<tr>
<th>Student Signature</th>
<th>Date:</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Signature</th>
<th>M.D. / D.O. / N.P. / P.A.</th>
<th>Date:</th>
</tr>
</thead>
</table>

*Signature of Healthcare Provider REQUIRED. May not be signed by student or family member*

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City/Town</th>
<th>State/County/Region</th>
<th>Country</th>
</tr>
</thead>
</table>
**PART 3A: TUBERCULOSIS (TB) MEDICAL EVALUATION:** *REQUIRED for any YES answers on TB Screening*

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

**Please Note:** Students who reside in one of the countries listed on the previous page are required to have TSpot TB testing upon arrival at Smith College, if IGRA documentation has not been submitted. Failure to provide complete documentation (except as described below) will result in the inability to travel to campus, register in classes, or participate in college-related events. Any person currently being treated for Active TB will be required to provide documentation of treatment and meet with the medical director upon arrival. **Any person being treated for Active TB without documentation will not be allowed on campus.**

1. **Does student have past or current diagnosis, signs, or symptoms of active tuberculosis disease?**
   - [ ] NO
   - [ ] YES

   Students with a history or current diagnosis of active Tuberculosis must provide the following:
   - [ ] Documentation from a tuberculosis specialist indicating that the student is **no longer infectious** and including treatment details:
     - Name(s) of medication, dose, frequency taken
     - Duration of treatment, start date(s) of treatment, date(s) treatment completed
     - Copies of all sputum results and chest X-rays.

2. **Interferon Gamma Release Assay (IGRA): Required if any yes answers on Part 3 or for any “positive” skin test.**

   **Type of Test:**
   - [ ] TSpot.TB test
   - [ ] QFT-GIT

   **Date of Test:** _____________

   **Result:**
   - Negative
   - Positive
   - Intermediate

   **Interpretation:**
   - [ ] If IGRA is negative, no further action is required. Attach lab results.
   - [ ] If IGRA is positive, a chest X-ray is required.

3. **Tuberculin Skin Test/PPD (TST): Required if no history of prior positive skin test and/or IGRA testing not available.**

   **Must be dated no earlier than May 1, 2018.**

   **Date given** ___ /___ /___
   **Date read** ___ /___ /___

   **Result:**
   - mm of induration, transverse diameter

   **Interpretation:**
   - [ ] Negative
   - [ ] Positive

   **Interpretation of Tuberculin Skin Test guidelines:** interpretation is based on mm of induration and risk factors below.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Result is considered POSITIVE if induration is equal or greater than:</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>No Risk Factor (Test not recommended)</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

4. **Chest x-ray: (Required if IGRA is positive OR if skin test is positive.) Must be dated no earlier than May 1, 2018.**

   **□** Date of chest x-ray ___ /___ /___
   **Result:**
   - Normal
   - Abnormal

   **Interpretation:**
   - [ ] If ABNORMAL see note at top of page.

   **□** Test Results Attached

**Signature**

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

**Date**

**Signature of healthcare provider REQUIRED. May not be signed by student or family member**

<table>
<thead>
<tr>
<th>Name of provider</th>
<th>Telephone ( )</th>
<th>Fax ( )</th>
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<tr>
<td>Address</td>
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