Schacht Center for Health and Wellness
and Pelham Medical Services
21 Belmont Avenue, Northampton, Massachusetts 01063
Phone 413-585-2800  Fax 413-585-4639  smith.edu/health

Deadlines:
June 15: Fall Admission, Undergraduate, Graduate, and Ada Comstock
January 19: Spring Admission

HEALTH FORM PACKET: REQUIRED OF ALL STUDENTS
► All pages must be completed with name, date of birth, and Smith ID number, and signed as indicated.
► Failure to submit this information by the deadline will result in a hold on student accounts.
► Please complete this checklist and all required documentation.

☐ Page 1: Student information, medical insurance, consent, and financial responsibility.
• Emergency contact must be a parent/guardian for students under age 18. One U.S. contact is preferred.
• Health insurance coverage is required for all students, as per Massachusetts law.
• Smith College offers a plan that is specifically designed to meet student needs. Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
• Students who waive the Student Health Insurance Plan must upload copies of both sides of their insurance cards.

☐ Page 2: Immunizations: Proof of required immunizations or immunity by blood test.
• Upload the enclosed form, completed and signed by your physician, OR a copy of your immunization record.
• Submit copies of blood test report(s) results if titers are being submitted.
• Questions about vaccine waivers should be directed to healthservices@smith.edu.

☐ Page 3: Tuberculosis Risk Screening: Date of screening must be within 3 months prior to matriculation.
• Tuberculosis screening question sheet must be completed and signed by the student or legally responsible parent/guardian.
• Testing is needed only if a student answers YES to any of the items on the screening questionnaire.

☐ Page 4: Tuberculosis Medical Evaluation: Complete only if you answer YES to questions on page 3. Date of testing must be within 3 months prior to matriculation.
• Medical provider (MD, DO, NP, PA) review and signature required if you answer YES to questions on page 3.
• Submit copies of written blood test report(s) and/or chest X-ray report(s), if applicable.

☐ Page 5: Medical Examination Form.
• Submit a copy of your recent physical exam: Date of exam must be within 23 months prior to matriculation.
• Your health care provider must review AND sign the medical examination form.

☐ Page 6: NCAA Pre-Participation Exam: Complete only if you intend to play an NCAA sport.
• Complete this form if you intend to play a team sport. Not required for club/extracurricular sports.
• Date of exam must be within 6 months prior to matriculation and before arrival on campus.
• EKG and referral to cardiology AND a copy of these records are required for any significant history and/or findings.
• Provide provider certification of negative sickle cell screening or a copy of a negative blood test result, as required by NCAA.

► UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL.
(https://smith.medicatconnect.com)
• Online instructions and additional forms are available at smith.edu/health.
• You may mail or fax records to 413-585-4639 if needed.
• Do not email forms, health records, or test results. They will not be accepted.

Failure to submit all required information by the deadline will result in a HOLD on student accounts. Clearance for registration, classes, and other activities is not granted until all required information is received.

QUESTIONS? Please contact healthservices@smith.edu or call 413-585-2800.
See website for information about health forms, insurance, services, and resources: smith.edu/health.
STUDENT INFORMATION
Chosen Name
Pronouns
Assigned Sex at Birth
Street Address
City/State/Region/Country/ZIP Code
Telephone
Email
Country of Birth
☐ Undergraduate
☐ Ada
☐ Graduate
☐ Transfer
Class of:

EMERGENCY CONTACT
Name of individual(s) over age 18 to be contacted in an emergency and who is able to make medical treatment decisions. If the student is younger than age 18, the legally responsible parent(s) or guardian must be listed first. Please include a U.S. contact.
Name
Relationship to Student
Telephone 1
Telephone 2
Email
Name
Relationship to Student
Telephone 1
Telephone 2
Email

MEDICAL INSURANCE - All students are automatically enrolled in the Student Health Insurance Plan.
• Health insurance coverage is required for all students per Massachusetts law. The Student Health Insurance Plan is available and is specifically designed to meet the needs of students. It is accepted by most off-campus providers in our local area without a referral, and covers vaccines and laboratory and radiology services. Deductibles and co-pays do apply.
• Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
• Students who waive the Student Health Insurance Plan should determine if LabCorp (on-site reference lab) is in-network and whether immunizations provided by the Schacht Center will be covered.
Students waiving the Student Health Insurance Plan MUST submit a copy of both sides of their insurance cards.
Students are responsible for any charges or services not covered by insurance.

FINANCIAL RESPONSIBILITY and CONSENT: Undergraduate, Graduate, and Ada Comstock Students only
I hereby give permission to the Schacht Center for Health and Wellness to provide me (or the aforementioned student under 18 years of age) with general, non-surgical medical treatment and diagnosis, including, but not limited to, immunizations or such other health care as the Schacht Center for Health and Wellness shall determine to be medically necessary or desirable. Further, in the event of a medical emergency when my emergency contact(s) identified above cannot be reached, I hereby give permission for the director of Smith College Health Services, or designee, to make treatment decisions for me (or the aforementioned student under 18 years of age), including, but not limited to, urgent or 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 life and/or recovery. Finally, I understand that charges for any services at the Schacht Center for Health and Wellness that are not covered by medical insurance will be billed to my account, for that I accept full financial responsibility.

Signature of student
Date
Required of all students

Signature of legally responsible parent or guardian
Date
Required of all students under 18 years of age

This page must be completed by all students. Student/parent/guardian signature required.
This page must be completed by all students. Physician signature required.

Last Name ______________________ First Name ______________________ Date of Birth / / Smith ID# 99 __________
MM DD YYYY

IMMUNIZATIONS

• ALL students must comply with Massachusetts School Immunization Requirements.

Failure to meet all requirements by the deadline 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.

<table>
<thead>
<tr>
<th>REQUIRED IMMUNIZATIONS: Include dates of administration in MM/DD/YYYY format</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
<td>Dose 4</td>
</tr>
<tr>
<td>Completed childhood primary series (date of final dose of DTP/DTaP)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap (Adacel or Boostrix)</td>
<td>1 dose within 10 years</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 doses (0, 1 month, 4–6 months apart) or positive titer (lab report required)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR: Measles, Mumps, Rubella</td>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td>MM/DD/YYYY</td>
<td></td>
</tr>
<tr>
<td>MMRV: Measles, Mumps, Rubella, Varicella</td>
<td>2 doses of MMR or MMRV</td>
<td>1st dose after 12 months of age</td>
<td>2nd dose at least 28 days after dose 1 or positive titers for each (lab report required)</td>
<td>N/A</td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>2 doses</td>
<td>1st dose after 12 months of age</td>
<td>2nd dose at least 28 days after dose 1 or positive titer (lab report required) or provider-verified medical documentation of disease with date</td>
<td>N/A</td>
</tr>
<tr>
<td>Quadrivalent Meningitis (Students age 21 or younger) (MenACWY/MCV4/Menactra/Menveo)</td>
<td>1 dose on or after age 16</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HIGHLY RECOMMENDED IMMUNIZATIONS

COVID-19 Please note the vaccine type in the corresponding date box. (booster) (booster) N/A

Hepatitis A N/A

Human Papillomavirus N/A

Polio primary series completed before age 4 N/A

Meningitis B (Students under age 23) N/A

☐ Bexsero ☐ Trumenba N/A

Flu Vaccine N/A

OTHER IMMUNIZATIONS

Japanese Encephalitis (Ixiaro) N/A

Rabies N/A

Typhoid (injectable) N/A

Typhoid (oral) N/A

Yellow Fever N/A

You must submit an official copy of your immunization records OR your physician must complete AND sign this form.

I HAVE REVIEWED THIS HISTORY WITH THE STUDENT AND ATTEST TO ITS ACCURACY.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>M.D./D.O. N.P./P.A.</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City/Town</td>
<td>State/County/Region</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>Telephone</td>
<td>Fax</td>
<td></td>
</tr>
</tbody>
</table>

Upload this completed page to the patient portal at smith.edu/health.

Your health care provider’s office may fax this form, test results, and a copy of your immunization records to 413-585-4639.
If the answer to any question below is YES, the Tuberculosis (TB) Medical Evaluation Form on page 4 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. Have you ever been a resident, volunteer, and/or employee of a high-risk congregate setting (i.e., correctional facility, long-term care, or homeless shelter) or a health care worker who served clients who are at increased risk for active TB?
   - Yes
   - No

4. Were you born in one of the countries listed below?
   - Yes
   - No

5. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks?
   - Yes
   - No

6. Please CIRCLE the country in which you were born AND any of the countries you lived in within the past five years, or traveled to for more than two weeks.

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

Source: https://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_April2023.pdf

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

If the answer to ANY of the questions above is YES:

- The Tuberculosis (TB) Medical Evaluation (page 4) must be completed and signed by a medical provider.

- You are required to have an Interferon Gamma Release Assay (IGRA blood test) or a Tuberculin Skin Test/PPD (TST) if IGRA is not available. This must be dated no earlier than May 1, 2024.

- If a Tuberculin Skin Test is completed, an IGRA blood test will be required upon arrival.

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

Signature of student
Signature of legally responsible parent or guardian

This page is to be completed by the student/family. Upload this completed page to the patient portal at smith.edu/health. Your health care provider’s office may fax this form, test results, and a copy of your immunization records to 413-585-4639.
TUBERCULOSIS (TB) MEDICAL EVALUATION

Please Note: Failure to provide complete documentation 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 a medical provider 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 page 3 or for any positive skin test.

   Type of Test: □ TSpot.TB test  OR  □ QFT-GIT  Date of Test: _____________  Must be dated no earlier than May 1, 2024.

   Result: Negative____  Positive____  Indeterminant____  (If Indeterminant, repeat IGRA testing will be required.)

   □ If IGRA is negative, no further action is required.
   □ If IGRA is positive, a chest X-ray is required.
   □ Please attach lab results.
   □ If IGRA is not available, complete section 3 below.

3. Tuberculin Skin Test/PPD (TST): Only complete if IGRA testing is not available. Must be dated no earlier than May 1, 2024.

   Please note: An IGRA blood test will be required upon arrival.

   Date given ___ /___ /______       Date read ___ /___ /______       Result: ______ mm of induration, transverse diameter

   Interpretation: □ Negative  □ Positive  (Chest X-ray required)

   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 two weeks 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, 2024.

   □ Date of chest X-ray ___ /___ /______       Result: Normal ____  Abnormal ____  If ABNORMAL, consultation with a medical provider is needed for medical clearance prior to arriving on campus.
   □ Attach chest X-ray report

I HAVE REVIEWED THIS FORM AND ATTEST THAT THE STUDENT IS AT LOW TO NO RISK FOR TUBERCULOSIS EXCEPT AS INDICATED ABOVE.

Provider Name  M.D./D.O.  N.P./P.A.  Signature  Date

Address  City/Town  State/County/Region

Country  Telephone  Fax

Upload this completed page to the patient portal at smith.edu/health. Your health care provider’s office may fax this form, test results, and a copy of your immunization records to 413-585-4639.
This page must be completed by all students. 
Provider signature required.

Last Name ___________________ First Name ___________________ Date of Birth / / Smith ID# 99 __________________ 

MM DD YYYY

MEDICAL EXAMINATION
Exam must be performed no earlier than August 1, 2022.
To be completed and signed by the health care provider. No portion of this form may be completed by a student’s family member.

HEALTH HISTORY: ☐ No known significant medical history
Check and provide dates and details below if there is a significant medical history:

☐ Hospitalization ☐ Surgery ☐ Anaphylaxis ☐ Abnormal Pap Smear ☐ ADD or ADHD ☐ Anemia ☐ Anxiety
☐ Alcohol or Drug Abuse ☐ Asthma Bronchitis/ Pneumonia/Lungs ☐ Bipolar Disorder ☐ Blood Clot or Phlebitis ☐ 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 ☐ Sickle Cell ☐ Other:
☐ Weight Change ☐ Paining or Loss of Consciousness ☐ Urinary Tract Infections ☐ Other: ☐ Other: ☐ Other:

PHYSICAL EXAM: Height _______ Weight _______ BMI _______

BP _______ HR _______ RR _______

Normal Description N/A

General constitutional

Head Ears Eyes Neck Throat

Heart / Cardiovascular

Respiratory / Lungs

Gastrointestinal

Genitourinary

Reproductive

Neurological

Immune / Lymphatic

Hematologic / Blood

Metabolic / Endocrine

Psychiatric

ALLERGIES: ☐ No Known Allergies ☐ Medications ☐ Food ☐ Insect Bites If so, list below and describe reaction.

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 NCAA Athletic Pre-Participation Physical Exam (page 6)

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.

DESCRIPTOR ABOVE:

Provider Name ___________________ Signature ___________________ Date __________________

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

Address ___________________ City/Town ___________________ State/County/Region ___________________

Country ___________________ Telephone ___________________ Fax ___________________

Upload this completed page to the patient portal at smith.edu/health.

Your health care provider’s office may fax this form, test results, and a copy of your immunization records to 413-585-4639.
### NCAA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM

**This form is required for students planning to play on an NCAA team.**

**Personal Health History**—Have you ever had:

<table>
<thead>
<tr>
<th>Condition</th>
<th>No/Never</th>
<th>If yes, provide description and dates if known.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury/concussion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Significant injury or fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma or breathing problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have an inhaler?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unexplained seizure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission to hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For what?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Concern for body weight and/or size</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age of first menstrual period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Missed more than three consecutive periods in the past 2 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you vape or smoke?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cardiac History**

<table>
<thead>
<tr>
<th>Condition</th>
<th>If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest pain, fainting, dizziness with exercise</td>
<td></td>
</tr>
<tr>
<td>Excessive breathlessness</td>
<td></td>
</tr>
<tr>
<td>Irregular heartbeat/arrhythmia/palpitations</td>
<td></td>
</tr>
</tbody>
</table>

**Has anyone in your immediate biological family had:**

<table>
<thead>
<tr>
<th>Condition</th>
<th>If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden or unexplained death before age 50, seizure, or drowning</td>
<td></td>
</tr>
<tr>
<td>Heart problem/heart attack</td>
<td></td>
</tr>
<tr>
<td>Diabetes, asthma, cancer or seizures</td>
<td></td>
</tr>
<tr>
<td>High blood pressure or blood clots</td>
<td></td>
</tr>
</tbody>
</table>

**Physical Exam**

<table>
<thead>
<tr>
<th>Section</th>
<th>Normal / Unremarkable</th>
<th>Findings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance (Assess for Marfan Stigmata)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head/Ears/Eyes/Nose/Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Assessment: Performed seated, supine, squatting, &amp; with Valsalva. Assess for murmurs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses (Femoral/Radial/Pedal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin (MRSA/HSV/Tinea)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurologic: including reflexes &amp; strength</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal: Neck/Back/Spine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal: Extremities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal: Joints</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision: R L Correct?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All participating student-athletes are required to provide confirmation of sickle cell trait status, either through: 1) existing documentation from birth, or 2) recent screening. If students are unable to access testing prior to arrival, labs can be completed at the Schacht Center. Lab fees and deductibles apply.

- [ ] I attest that student has negative sickle cell screening.
- [ ] Or a copy of the student's negative sickle cell testing is attached. (Provide copy of results).

Please attach further notes as desired.

- [ ] CLEARED FOR ALL ATHLETICS WITHOUT RESTRICTION
  - [ ] Not cleared for athletics: Advise further evaluation for
  - [ ] EKG performed and attached. Referred to Cardiology: Name of Provider ________ Date of Appointment ________
  - [ ] Cardiology clearance letter attached, if applicable.

I HAVE EXAMINED THE ABOVE-NAMED STUDENT. MY FINDINGS AND RECOMMENDATIONS ARE AS INDICATED ABOVE.

<table>
<thead>
<tr>
<th>Provider Name</th>
<th>M.D./D.O.</th>
<th>N.P./P.A.</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City/Town</td>
<td>State/County/Region</td>
<td>Telephone</td>
<td>Fax</td>
</tr>
</tbody>
</table>

Upload this completed page to the patient portal at smith.edu/health.

Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.