HEALTH FORM PACKET: REQUIRED OF ALL STUDENTS

► All pages must be completed with name, date of birth, Smith ID number, and signed as indicated.
► All students must submit proof of required immunizations and tuberculosis screening.
► Failure to submit this information by deadline will result in a hold on student accounts.

□ Student information, medical insurance, consent and financial responsibility (page 1).
  • Emergency contact must be parent/guardian for students under age 18. One U.S. contact is preferred.
  • We highly recommend all students purchase the Student Health Insurance Plan. See our website for details.
  • Contact Student Financial Services at 413-585-2530 with questions about waiving/purchasing health insurance.
  • Students with private insurance must submit a copy of both sides of their insurance cards.

□ Immunizations: Submit proof of required immunizations or immunity by blood test (page 2).
  • Complete the online form with dates of your immunizations. This form is on the patient portal.
  • Upload the enclosed form, completed and signed by your physician OR a copy of your immunization record.

□ Tuberculosis Screening: Date of screening/testing must be within 3 months prior to matriculation (page 3).
  • Tuberculosis screening questions must be completed and signed by student AND provider.
  • Testing is needed ONLY if a student answers YES to any of the items on the screening questionnaire.
  • Submit copies of written blood test report(s) and/or chest X-ray report(s).

□ Physical Exam and Health History: Required of undergraduate, Ada Comstock and graduate students (page 4).
  • 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 history form.
  • Graduate students: must submit this information before seeking care at the Schacht Center.

□ Athletes Only: NCAA pre-participation exam.
  • 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 is required for any significant history and/or findings.

► UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL
  • Online instructions and additional forms are at www.smith.edu/health.
  • You may mail or fax records if needed.
  • Emailed forms, health records and test results are NOT 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 413-585-2250.
See website for information about health forms, insurance, services and resources: www.smith.edu/health.

UPLOAD or MAIL all information.
We do not accept emailed information due to confidentiality concerns.
Keep a copy of all information sent.
STUDENT INFORMATION

Preferred Name  Preferred Pronouns  Assigned Sex at Birth

Street Address

City/State/Region/Country

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  Telephone  Email

Name  Relationship to Student

Telephone  Telephone  Email

MEDICAL INSURANCE - All students are automatically enrolled in the Student Health Insurance Plan

All students are strongly encouraged to purchase the Student Health Insurance Plan as it is specifically designed to meet the needs of students. It covers vaccines, laboratory and radiology services, and is accepted by most off-campus providers in our local area without a referral. Cards can be obtained online in September. See our website for further detail.

Deductibles and copays do apply.

Please direct any questions regarding purchasing or waiving the Student Health Insurance Plan to Student Financial Services at 413-585-2530.

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 medical emergency and 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 which are not covered by medical insurance will be billed to my account, for which 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 is to be completed by student/family. Upload this completed page to the patient portal at www.smith.edu/health. Do not give this page to your doctor.
IMMUNIZATIONS

- ALL students must comply with Massachusetts School Immunization Requirements.
- Complete the online immunization record under New Student Resources at www.smith.edu/health.
- ALSO submit a copy of your immunization records OR this form, signed by your physician.
- If titer blood tests were performed, submit a copy of test results.

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:</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>TITER: Date and Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Include dates of administration in MM/DD/YYYY format</td>
<td>Dose 1</td>
<td>Dose 2</td>
<td>Dose 3</td>
<td>Dose 4</td>
<td>Include copy of results if titer are performed</td>
</tr>
<tr>
<td>Tdap (Adacel/Boostrix)</td>
<td>1 dose within 10 years</td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3 doses (0, 1 month, 4-6 months apart)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or positive titer (submit results)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR: Measles, Mumps, Rubella</td>
<td>2 doses of MMR or MMRV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMRV: Measles, Mumps, Rubella, Varicella</td>
<td>1st dose after 12 months of age</td>
<td>2nd dose at least 28 days after dose 1</td>
<td>or positive titers for each (submit results)</td>
<td></td>
<td></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</td>
<td>or positive titer (submit results)</td>
<td>or physician-verified medical documentation of disease with date</td>
</tr>
<tr>
<td>Quadrivalent Meningitis (Students under age 27)</td>
<td>(MenACWY/MCV4/Menactra/Menveo)</td>
<td>1 dose after age 16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highly Recommended Immunizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTP primary series</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papilloma Virus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio primary series completed before age 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Meningitis B (Students under age 27)</td>
<td>2 doses of Bexsero OR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 doses Trumenba</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Immunizations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Japanese Encephalitis (Ixiaro)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Rabies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Typhoid (injectable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typhoid (oral)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (i.e., flu)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You must submit a 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.

Name of Provider 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 www.smith.edu/health.

Your healthcare provider’s office may fax this form, test results and a copy of your immunization records to 413-585-4639.
TUBERCULOSIS (TB) RISK SCREENING QUESTIONNAIRE: Complete within 3 months prior to matriculation.

In what country were you born? _______________________

Have you ever had a positive tuberculosis (TB) skin test?  □ No  □ Yes  Date ____________

Have you ever had close contact with anyone who was sick with TB?  □ No  □ Yes  Date ____________

Were you born in one of the countries listed below? If yes, where: _______________________

Did you arrive in the U.S. within the past five years?  □ No  □ Yes  Date ____________

Have you (or will you**) travel(ed) for more than two weeks to/in any of the country/ies listed below?  □ No  □ Yes  Date ____________

CIRCLE any of the countries you traveled in or to within the past 5 years and include dates of travel.

**If student travels to any country listed here after the date of initial screening—testing MUST be performed before arrival on campus.

- Afghanistan
- Angola
- Armenia
- Azerbaijan
- Bangladesh
- Belarus
- Botswana
- Brazil
- Bulgaria
- Burkina Faso
- Burundi
- Cambodia
- Cameroon
- Central African Republic
- Chad
- Democratic Republic of the Congo
- China
- Indonesia
- Kazakhstan
- Kyrgyzstan
- Libya
- Lesotho
- Liberia
- Lithuania
- Malawi
- Mali
- Mauritania
- Mexico
- Myanmar
- Namibia
- Nepal
- Nigeria
- Pakistan
- Papua New Guinea
- Peru
- Philippines
- Russian Federation
- Rwanda
- Sierra Leone
- Somalia
- South Africa
- Sudan
- Swaziland
- Tajikistan
- United Republic of Tanzania
- Thailand
- Uganda
- Ukraine
- Uzbekistan
- Vietnam
- Zambia
- Zimbabwe

If the answer to ALL questions above is NO, sign here: __________________________  Physician signature required below.

If the answer to ANY question above is YES:

Does the student have a past or current diagnosis or any symptoms of active tuberculosis?  □ Yes  □ No

If YES: Provide documentation of treatment dates, medications taken, sputum results and chest X-ray reports.

Blood test is required if any question above is marked YES.

Perform an Interferon Gamma Release Assay (IGRA): TSPOT or Quantiferon Gold AND attach copy of test results.

Date of blood test: ____________ Result: Negative ___ Positive ___ Intermediate ___  □ Submit copy of test results

If blood test is not available, a PPD skin test and/or chest X-ray can be performed as a temporary screening measure.

If IGRA is negative, no further action is required.

TB IGRA testing MUST be completed prior to arrival on campus.

Chest X-ray required if blood test is positive OR indeterminate OR not available.

Provide full narrative copies of blood test reports AND chest X-ray reports, preferably in English.

Chest X-ray: Date of chest X-ray: ____________ Result: Normal ___ Abnormal ___  □ Submit copy of test results

ABNORMAL RESULTS require immediate medical evaluation. Contact our office promptly.

Any person with abnormal results, symptoms of TB, OR being treated for TB must CONTACT OUR OFFICE BEFORE ARRIVAL and meet with campus physician immediately upon arrival at Smith College.

Failure to provide complete documentation AND copies of test reports will result in the inability to reside on campus, register for classes or participate in college-related events.

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

Name of Provider: __________________________

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

Signature: __________________________

Date: __________________________

Address: __________________________

City/Town: __________________________

State/County/Region: __________________________

Country: __________________________

Telephone: __________________________

Fax: __________________________
HEALTH HISTORY: Required for all students

ALLERGIES: □ Medications □ Food □ Bee/Wasp/Insect □ Environmental □ NO KNOWN ALLERGIES

Students with significant allergies are advised to carry an EPI-Pen at all times AND register with the Office of Disability Services.

<table>
<thead>
<tr>
<th>Item</th>
<th>Reaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICATION: List medications used. Include inhalers, hormones and contraception. □ NO MEDICATIONS USED

<table>
<thead>
<tr>
<th>Medication/Dose</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FAMILY HISTORY: Are all members of your immediate biological family (parents and siblings) living and healthy? □ Yes □ No

If no, please explain:

Check if an immediate biological family member has had:

□ Sudden death before age 50 □ Unexplained death, drowning or seizure □ Heart attack □ Blood clot

□ Heart disease □ High blood pressure □ Diabetes □ Cancer □ Asthma □ Lung disease

PAST MEDICAL HISTORY* (Attach further notes as desired.)

Age of first menstrual period: ________________ □ Never

Do you vape, smoke or use tobacco? □ Yes □ No □ Never

Have you ever had or been diagnosed with: Yes No/Never Please provide description and dates (if known)

- Admission to or overnight stay in hospital for any reason
- Surgery
- Broken bone or fracture
- Concussion or head injury *
- Migraine headache
- Anemia
- Seizure*
- Loss of consciousness/fainting spells*
- Asthma or other breathing trouble
- Diabetes*
- Abnormal thyroid
- Bleeding problems or blood clotting disorder
- High blood pressure
- Sickle cell anemia/sickle cell trait
- Unexplained appetite or weight changes
- Eating disorder*
- Mood disorder or bipolar disorder
- Anxiety and/or depression
- Have you ever seen a psychiatrist, therapist or counselor
- Learning difference, such as dyslexia or ADHD*

*Students with complex medical histories or questions are invited to contact our office.

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

Name of Provider 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 www.smith.edu/health.

Your healthcare provider’s office may fax this form, test results and a copy of your immunization records to 413-585-4639.
This page is only required for NCAA Athletes. Other students may complete this physical exam form if desired.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Smith ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>99</td>
</tr>
</tbody>
</table>

**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:**

- Head injury/concussion
- Significant injury or fracture
- Asthma or breathing problem Do you have an inhaler?
- Admission to hospital (For what?)
- Concern for body weight and/or size
- Age of first menstrual period
- Are periods regular?
- Do you vape or smoke? What?

**Cardiac History**

- Unexplained seizure When?
- Chest pain, fainting, dizziness with exercise
- Excessive breathlessness
- Irregular heartbeat/arrhythmia/palpitations

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

If Yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS

- Sudden or unexplained death before age 50, seizure, or drowning
- Heart problem/heart attack
- Diabetes, asthma, cancer or seizures
- High blood pressure or blood clots

**Height** Height **Weight** **BMI**

**Assigned sex at birth:**

**Gender:**

**Does student meet Massachusetts Immunization Requirements?** □ YES □ IF NOT, EXPLAIN:

**Blood Pressure**

<table>
<thead>
<tr>
<th>Blood Pressure</th>
<th>Pulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision: R</td>
<td></td>
</tr>
<tr>
<td>Corrected: L</td>
<td></td>
</tr>
</tbody>
</table>

**Tuberculosis Screening:**

- No/Low Risk: □
- High Risk: □ IGRA or CXR performed? □ Result:

**LIST ALLERGIES:**

**Is EpiPen needed?** Yes/No

**LIST MEDICATIONS:**

Renew all prescriptions.

**Physical Exam**

<table>
<thead>
<tr>
<th>Appearance (Assess for Marfan Stigmata)</th>
<th>Normal / Unremarkable</th>
<th>Findings:</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

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 ________________

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

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>M.D./ D.O./ N.P./ P.A.</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City/Town</th>
<th>State/County/Region</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Country</th>
<th>Telephone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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