Deadlines:
June 15: Fall Admission, Undergraduate, Graduate and Ada Comstock
January 11: 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.

☐ 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: 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 Risk 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, and must complete page 4.
  • Submit copies of written blood test report(s) and/or chest X-ray report(s).

☐ Medical Examination Form (page 5).
  • 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.

☐ 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 smith.edu/health.
  • You may mail or fax records 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 413-585-2250.
See website for information about health forms, insurance, services and resources: smith.edu/health.
Last Name ___________________________ First Name ___________________________ Date of Birth __/__/________ Smith ID# 99 __________

STUDENT INFORMATION

<table>
<thead>
<tr>
<th>Preferred Name</th>
<th>Preferred Pronouns</th>
<th>Assigned Sex at Birth</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to Student</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>Telephone 1</td>
<td>Telephone 2</td>
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<tr>
<td>Email</td>
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<tr>
<td>Name</td>
<td>Relationship to Student</td>
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<tr>
<td>Telephone 1</td>
<td>Telephone 2</td>
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<tr>
<td>Email</td>
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</table>

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 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.

<table>
<thead>
<tr>
<th>Signature of student</th>
<th>Date</th>
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<tr>
<td>Required of all students</td>
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<tr>
<th>Signature of legally responsible parent or guardian</th>
<th>Date</th>
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<tbody>
<tr>
<td>Required of all students under 18 years of age</td>
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</table>

This page is to be completed by student/family. Upload this completed page to the patient portal at smith.edu/health. Do not give this page to your doctor.
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.

### REQUIRED IMMUNIZATIONS:

Include dates of administration in MM/DD/YYYY format

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date</th>
<th>Dose 1</th>
<th>Date</th>
<th>Dose 2</th>
<th>Date</th>
<th>Dose 3</th>
<th>Date</th>
<th>Dose 4</th>
<th>TITER: Date and Result Include copy of results if titers are performed</th>
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<tbody>
<tr>
<td>COVID-19</td>
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<td>N/A</td>
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<td>Johnson &amp; Johnson (Janssen)</td>
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<td>□ Moderna</td>
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<td>Tdap (Adacel/Boostrix)</td>
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<td>1 dose within 10 years</td>
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<td>Hepatitis B</td>
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<td>3 doses (0, 1 month, 4-6 months apart)</td>
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<td>1 dose within 10 years</td>
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<td>MMR: Measles, Mumps, Rubella</td>
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<td>2 doses of MMR or MMRV</td>
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<td>1st dose after 12 months of age</td>
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<td>2nd dose at least 28 days after dose 1</td>
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<td>or physician-verified medical documentation of disease with date</td>
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<td>Quadrivalent Meningitis (Students under age 27)</td>
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<td>1 dose after age 16</td>
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### HIGHLY RECOMMENDED IMMUNIZATIONS

DTP primary series
Hepatitis A
Human Papillomavirus
Polio primary series completed before age 4
N/A
Meningitis B (Students under age 27)
□ Bexsero □ Trumenba
Flu Vaccine

### OTHER IMMUNIZATIONS

Japanese Encephalitis (Ixiaro) N/A
Rabies N/A
Typhoid (injectable)
Typhoid (oral)
Yellow Fever

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.

Provider Name M.D./ D.O. N.P./ P.A. Signature Date
Address City/Town State/County/Region Telephone Fax

Upload this completed page to the patient portal at 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 (Required for ALL Students)

If the answer to any question below is YES, the Tuberculosis (TB) Medical Evaluation Form 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 in the U.S. within the past five years or are you planning to arrive soon? □ 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 five years. Mark with a T for travel and include dates

Angola Angola China China Kenya Kenya Papua New Guinea Papua New Guinea Thailand Thailand
Azerbaijan Azerbaijan Congo Congo Kyrgyzstan Kyrgyzstan Peru Peru Uganda Uganda
Bangladesh Bangladesh DPR Korea DPR Korea Lesotho Lesotho Philippines Philippines Ukraine Ukraine
Belarus Belarus DR Congo DR Congo Liberia Liberia Republic of Moldova Republic of Moldova UR Tanzania UR Tanzania
Botswana Botswana Ethiopia Ethiopia Malawi Malawi Russian Federation Russian Federation Uzbekistan Uzbekistan
Brazil Brazil Ghana Ghana Mozambique Mozambique Sierra Leone Sierra Leone Vietnam Vietnam
Cambodia Cambodia Guinea-Bissau Guinea-Bissau Myanmar Myanmar Somalia Somalia Zambia Zambia
Cameroon Cameroon India India Namibia Namibia South Africa South Africa Zimbabwe Zimbabwe
Central African Republic Central African Republic Indonesia Indonesia Nigeria Nigeria Swaziland Swaziland
Chad Chad Kazakhstan Kazakhstan Pakistan Pakistan Tajikistan Tajikistan


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

If the answer to ANY of the questions above is YES:
☐ The Tuberculosis (TB) Medical Evaluation Form must be completed (page 4).
☐ 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, 2021. 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.

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 healthcare 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. Physician signature required.

Last Name: ___________________________ First Name: ___________________________ Date of Birth: ___ / ___ / _______ Smith ID# 99 _________

TUBERCULOSIS (TB) MEDICAL EVALUATION: REQUIRED for any YES answers on TB Screening

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 OR □ QFT-GIT Date of Test: ____________ Must be dated no earlier than May 1, 2021

Result: Negative___ Positive___ Intermediate___ If IGRA is positive, a chest X-ray is required.

• If IGRA is negative, no further action is required. Attach lab results.

3. Tuberculin Skin Test/PPD (TST): Required if no history of positive skin test and/or IGRA testing not available. Must be dated no earlier than May 1, 2021.

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, 2021.

□ Date of chest X-ray ___ / ___ / ______ Result: Normal _____ Abnormal _____ If ABNORMAL see note at top of page.

□ Test Results Attached

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 healthcare 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.
Physician signature required.

Last Name ___________________________ First Name ___________________________ Date of Birth __ __ __________ Smith ID# 99 __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

MEDICAL EXAMINATION
Exam must be performed no earlier than August 1, 2019.*
To be completed and signed by the healthcare provider. No portion of this form may be completed by student 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 □ Fractures □ 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
□ Weight Change □ Fainting or Loss of Consciousness □ Urinary Tract Infections □ Other □ Other □ Other

PHYSICAL EXAM: Height _______ Weight _______ BMI________________
BP _______ HR __________ RR __________

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

□ No Known Allergies □ Medications □ Food □ Insect Bites If so, 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.

□ 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

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 healthcare 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:**

- 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:**

- 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**  **Weight**  **BMI**  **Assigned sex at birth:**

**Gender:**

**Does student meet Massachusetts Immunization Requirements?**

- Yes  
- No  

**Blood Pressure**  **Pulse**

**Vision:**  **R**  **L**  Corrected?

**Tuberculosis Screening:**

- No/Low Risk:
- High Risk:

**LIST ALLERGIES:**

**Is EpiPen needed?**

- Yes  
- No

**LIST MEDICATIONS:**

- Renew all prescriptions.

**Physical Exam**

- Normal / Unremarkable

**Findings:**

- Appearance (Assess for Marfan Stigmata)
- Head/Ears/Eyes/Nose/Throat
- Lymph Nodes
- Pulses (Femoral/Radial/Pedal)
- Lungs
- Abdomen
- Skin (MRSA/HSV/Tinea)
- Neurologic: including reflexes & strength
- Psychiatric
- Musculoskeletal: Neck/Back/Spine
- Musculoskeletal: Extremities
- Musculoskeletal: Joints

**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.**

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