



*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.**
- ▶ **Please complete this checklist and all required documentation.**
  
- Page 1: Student information, medical insurance, consent and financial responsibility.**
  - 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.
  
- 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.
  
- Page 3: Tuberculosis Risk Screening: Date of screening/testing must be within 3 months prior to matriculation.**
  - Tuberculosis screening questions must be completed and signed by a provider.
  - 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.**
  - 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 at [smith.edu/health](http://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](mailto:healthservices@smith.edu) or call 413-585-2800.**

**See website for information about health forms, insurance, services and resources: [smith.edu/health](http://smith.edu/health).**

UPLOAD all information.

We do not accept emailed information due to confidentiality concerns.

Keep a copy of all information sent.

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Smith ID# 99** \_\_\_\_\_  
MM DD YYYY

**STUDENT INFORMATION**

Chosen Name \_\_\_\_\_ Chosen 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**

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.*

<b>Signature of student</b>	<b>Date</b>
<i>Required of all students</i>	
<b>Signature of legally responsible parent or guardian</b>	<b>Date</b>
<i>Required of all students under 18 years of age</i>	

**This page is to be completed by student/family. Upload this completed page to the patient portal at [smith.edu/health](http://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.

<b>REQUIRED IMMUNIZATIONS:</b> Include dates of administration in MM/DD/YYYY format	Date Dose 1 MM/DD/YYYY	Date Dose 2 MM/DD/YYYY	Date Dose 3 MM/DD/YYYY	Date Dose 4 MM/DD/YYYY	TITER: Date and Result <i>Include copy of results if titers are performed</i>
<b>Tetanus-Diphtheria-Pertussis</b> Completed childhood primary series (date of final dose of DTP/DTaP)					N/A
<b>Tdap (Adacel or Boostrix)</b> 1 dose within 10 years					N/A
<b>Hepatitis B</b> (Specify if Heplisav-B) 3 doses (0, 1 month, 4-6 months apart) or positive titer (lab report required)					
<b>MMR: Measles, Mumps, Rubella</b> <b>MMRV: Measles, Mumps, Rubella, Varicella</b> 2 doses of MMR or MMRV 1st dose after 12 months of age 2nd dose at least 28 days after dose 1 or positive titers for each (lab report required)					
<b>Varicella</b> (Chicken Pox) 2 doses 1st dose after 12 months of age 2nd dose at least 28 days after dose 1 or positive titer (lab report required) or provider-verified medical documentation of disease with date					
<b>Quadrivalent Meningitis</b> (Students age 21 or younger) (MenACWY/MCV4/Menactra/Menveo) 1 dose on or after age 16					N/A
<b>HIGHLY RECOMMENDED IMMUNIZATIONS</b>					
<b>COVID-19</b> 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) <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba					N/A
Flu Vaccine					N/A
<b>OTHER IMMUNIZATIONS</b>					
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.**

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

**Upload this completed page to the patient portal at [smith.edu/health](http://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.**

**Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Date of Birth** / / \_\_\_\_\_ **Smith ID# 99** \_\_\_\_\_  
MM DD YYYY

**TUBERCULOSIS (TB) RISK SCREENING (Required for ALL Students) Complete within 3 months prior to matriculation.**

If the answer to any question below is **YES**, the Tuberculosis (TB) Medical Evaluation Form on page 4 must be completed.

- |  |  |
|--|--|
|  | <b>Date(s)</b>   |
| 1. Have you ever had a positive tuberculosis (TB) skin test?   | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 2. Have you ever had close contact with anyone who was sick with TB?   | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 3. Were you born in one of the countries listed below?   | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 4. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks?  | <input type="checkbox"/> Yes <input type="checkbox"/> No _____ |
| 5. 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	Colombia	Haiti	Mozambique	Solomon Islands
Algeria	Comoros	Honduras	Myanmar	Somalia
Angola	Congo	India	Namibia	South Africa
Anguilla	Côte d'Ivoire	Indonesia	Nauru	South Sudan
Argentina	Democratic People's Republic of Korea	Iraq	Nepal	Sri Lanka
Armenia	Democratic Republic of the Congo	Kazakhstan	Nicaragua	Sudan
Azerbaijan	Djibouti	Kenya	Niger	Suriname
Bangladesh	Dominican Republic	Kiribati	Nigeria	Tajikistan
Belarus	Ecuador	Kuwait	Niue	Thailand
Belize	El Salvador	Kyrgyzstan	Northern Mariana Islands	Timor-Leste
Benin	Equatorial Guinea	Lao People's Democratic Republic	Pakistan	Togo
Bhutan	Eritrea	Latvia	Palau	Tokelau
Bolivia (Plurinational State of)	Eswatini	Lesotho	Panama	Trinidad and Tobago
Bosnia and Herzegovina	Ethiopia	Liberia	Papua New Guinea	Tunisia
Botswana	Fiji	Libya	Paraguay	Turkmenistan
Brazil	French Polynesia	Lithuania	Peru	Tuvalu
Brunei Darussalam	Gabon	Madagascar	Philippines	Uganda
Bulgaria	Gambia	Malawi	Portugal	Ukraine
Burkina Faso	Georgia	Malaysia	Qatar	United Republic of Tanzania
Burundi	Ghana	Maldives	Republic of Korea	Uruguay
Cabo Verde	Greenland	Mali	Republic of Moldova	Uzbekistan
Cambodia	Guam	Marshall Islands	Romania	Vanuatu
Cameroon	Guatemala	Mauritania	Russian Federation	Venezuela (Bolivarian Republic of)
Central African Republic	Guinea	Mexico	Rwanda	Viet Nam
Chad	Guinea-Bissau	Micronesia (Federated States of)	Sao Tome and Principe	Yemen
China	Guyana	Mongolia	Senegal	Zambia
China, Hong Kong SAR		Morocco	Sierra Leone	Zimbabwe
China, Macao SAR			Singapore	

Source: [https://www.acha.org/documents/resources/guidelines/ACHA\\_Tuberculosis\\_Screening\\_Feb2021.pdf](https://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_Feb2021.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 Form must be completed (page 4).
- 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, 2023.
- 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.

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

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

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Smith ID# 99 \_\_\_\_\_  
MM DD YYYY

**TUBERCULOSIS (TB) MEDICAL EVALUATION**

**Please Note:** If IGRA documentation has not been submitted, students who reside in one of the countries listed on page 3 are required to have a TB IGRA blood test upon arrival at Smith College. 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 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, 2023**  
 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, 2023.**

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

Date given \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date read \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Result: \_\_\_\_\_ mm of induration, transverse diameter  
MM DD YYYY MM DD YYYY

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

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

Risk Factor	Result is considered <b>POSITIVE</b> if induration is equal or greater than:
Close contact with an individual with infectious tuberculosis	<b>5 mm or more</b>
Born in a country that has a high rate of tuberculosis	<b>10 mm or more</b>
Traveled or lived for two weeks or more in a country that has a high rate of tuberculosis	<b>10 mm or more</b>
No risk factor (Test not recommended)	<b>15 mm or more</b>

**4. Chest X-ray: Required if IGRA is positive OR if skin test is positive. Must be dated no earlier than May 1, 2023.**

- 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.*  
MM DD YYYY
- Attach chest X-ray report  Attach consultation note

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

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

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth     /     /     Smith ID# **99** \_\_\_\_\_  
MM DD YYYY

**MEDICAL EXAMINATION**

Date of Exam \_\_\_\_\_

*Exam must be performed no earlier than August 1, 2021.*

**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:

<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Surgery	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Abnormal Pap Smear	<input type="checkbox"/> ADD or ADHD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Alcohol or Drug Abuse	<input type="checkbox"/> Asthma Bronchitis/Pneumonia/Lungs	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Blood Clot or Phlebitis	<input type="checkbox"/> Bowel Disease	<input type="checkbox"/> Cancer	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Ears or Hearing	<input type="checkbox"/> Eyes or Vision	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Emotional or Mood Changes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Head Injury or Concussion	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Immune System	<input type="checkbox"/> Kidney Stones or Disease	<input type="checkbox"/> Learning Differences	<input type="checkbox"/> Liver or Hepatitis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Metabolic/Endocrine	<input type="checkbox"/> Migraine or Other Headaches	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Orthopedic or Bones	<input type="checkbox"/> Reproductive System/Menstruation	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Other:
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Fainting or Loss of Consciousness	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> 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.*


**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 NCAA Athletic Pre-Participation Physical Exam (page 6)*

**DESCRIBE ABOVE:**

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

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Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Smith ID# 99 \_\_\_\_\_  
Exam must be performed within 6 months of matriculation. MM DD YYYY

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:	No/Never	If Yes, provide description and dates if known.
Head injury/concussion		
Significant injury or fracture		
Asthma or breathing problem Do you have an inhaler?		
Unexplained seizure When?		
Admission to hospital (For what?)		
Concern for body weight and/or size		
Age of first menstrual period		
Missed more than three consecutive periods in the past 2 years?		
Do you vape or smoke? What?		
Cardiac History		If Yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS
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		

Physical Exam	Normal / Unremarkable	Findings:
Appearance (Assess for Marfan Stigmata)		
Head/Ears/Eyes/Nose/Throat		
Lymph Nodes		
Cardiac Assessment: Performed seated, supine, squatting & with Valsalva. Assess for murmurs.		
Pulses (Femoral/Radial/Pedal)		
Lungs		
Abdomen		
Skin (MRSA/HSV/Tinea)		
Neurologic: including reflexes & strength		
Psychiatric		
Musculoskeletal: Neck/ Back/ Spine		
Musculoskeletal: Extremities		
Musculoskeletal: Joints		
Vision: R L Corrected?		

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.**

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

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