FMA
FAMILY MEDICINE ASSOCIATES
AT ENDICOTT COLLEGE

376 Hale Street • Beverly, Massachusetts 01915
Tel: 978-232-2104 ~ Fax: 978-998-8004 ~ Email: fma@endicott.edu

# HEALTH FORM 2016–17

## UNDERGRADUATE DAY DIVISION STUDENTS
## (BEVERLY CAMPUS)

**PLEASE NOTE: ALL NEW STUDENTS must see that this form is completed, signed, and returned to the Health Center NO LATER THAN JULY 15, 2016 FOR FALL SEMESTER OR JANUARY 15, 2017 FOR SPRING SEMESTER.**

**Mail to: Family Medicine Associates at Endicott College, 376 Hale Street, Beverly, MA 01915 or FAX to 978-998-8004**
ANY STUDENT FAILING TO DO SO WILL BE PROHIBITED FROM RESIDING ON CAMPUS.
We recommend that you make and keep a copy of this form for your records.
*Your health information is confidential and protected by state and federal law. Endicott College is dedicated to protecting your rights.*

**ALL ATHLETES MUST MAKE TWO COPIES OF THIS ENTIRE FORM AND SEND ONE TO THE ATHLETIC TRAINING DEPARTMENT AND ONE TO THE HEALTH CENTER.**

**Endicott Varsity or Club Team(s)** _____

## Instructions for Completing All Necessary Health Forms

### Health Form Sections

- The student fills out the "Student Information" section.
- Your health care provider (physician or nurse practitioner) fills out the "Medical and Immunization History" and "Physical Examination" sections. Your physical examination must have been done within the last 12 months.

  Your health care provider may elect to submit this information on their own paperwork, as long as the information is on the practice's letterhead or stamped with the medical practice's information.

### Tuberculosis Risk Assessment

- The "Tuberculosis Risk Assessment" is a two-sided form. (The student fills out side one, and if he or she answers "no" to all of the risk questions, there is no need to fill out side two.)

  If the answer to any of the questions is yes, the student's health care provider must complete side two.

### Information on Meningococcal Disease

The form titled "Information about Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and Colleges" is a separate document from this Health Form. It explains that all resident students must have had the meningococcal vaccine within the past five years or must complete the waiver form. It is not a requirement for commuter students to receive the vaccine or to complete the waiver form.

If you misplace the forms, additional forms can be accessed on the Endicott College Health Center web page at http://www.endicott.edu/StudentLife/Health-Center/Health-Forms.aspx. Resident students will not be permitted to move on campus until all health forms are received. If you have any questions or concerns, please contact Family Medicine Associates (FMA) at Endicott College at (978) 232-2104 or fma@endicott.edu.

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FMA at Endicott
(978) 232-2104
fma@endicott.edu

# Student Information

**To be completed by student**

Name of Student _____ Endicott ID # _____
Last First Middle

Date of Birth _____/_____/_____ Gender _____ Place of Birth _____
Month Day Year Country

Permanent Street Address _____

City _____ State _____ Zip Code _____

Student's Telephone Numbers: home (_____) _____ cell (_____) _____

Student's Email _____

Academic Year (check one): ❒ Freshman ❒ Sophomore ❒ Junior ❒ Senior

**TO BE SIGNED BY STUDENT**

I grant permission to FMA to release a copy of this Health Form to relevant personnel within the College for the purpose of obtaining information required for my major and/or athletic involvement. I understand that Endicott College cannot be held responsible for the accuracy of the information contained herein.

Student Signature_____ Date _____

## Emergency Contacts

Name _____ Relationship to Student _____

Permanent Street Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

Name _____ Relationship to Student _____

Permanent Street Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____ Business Phone (_____) _____ Cell Phone (_____) _____

## Consent for Emergency Treatment

**To be signed by parent/guardian <u>if student is under 18 years of age</u>**

I give permission for medical treatment for my son/daughter if an accident/illness should occur while he/she is a student at Endicott College. This includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I cannot be reached.

Parent/Guardian Name (print)_____ Relationship to Student _____

Parent/Guardian Signature _____ Phone _____ Date _____

## Health Insurance Information (Required)

**Please attach a photocopy of the front and back of your health insurance card.**

In accordance with Massachusetts state law, students must provide proof of health insurance that is current and valid.

Insurance Company _____ ID# _____ Group# _____

Name of Subscriber _____ Subscriber Date of Birth _____

Please bring to campus information about deductibles, co-pay amounts, and referrals required by your insurance provider.

## For Students with Disabilities

**(PHYSICAL, PSYCHOLOGICAL, OR LEARNING)**

**Please notify the Office of Academic Resources at 978-232-2292**
**Staff members there can discuss your needs and requests with you.**

# MEDICAL AND IMMUNIZATION HISTORY

**To be completed and signed by health care provider at time of examination**

Student Name _____ Date of Birth _____

**MASSACHUSETTS LAW (College Immunization Law, Chapter 76, Section 15c)** and Endicott College require verification of immunity for measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, and varicella. Exact dates are required for all immunizations and/or serological test results. **If serology titer is done, please attach copy of report.** If serology titer indicates lack of immunity, vaccines must be administered. Immunizations administered prior to first birthday are invalid. History of diseases is not acceptable documentation of immunity, except for varicella. No documentation for varicella is required for those born before 1980.

## I. REQUIRED IMMUNIZATIONS

**Month / Day / Year**

**A. MMR (Measles, Mumps, Rubella): Two doses required**

❒ Dose 1 Immunized on or after first birthday — Dose 1 _____/_____ /_____

❒ Dose 2 Given at least one month after Dose 1 — Dose 2 _____/_____ /_____

**or**

**Documentation of positive antibody titer**

Measles titer: Date _____/_____ /_____

Mumps titer: Date _____/_____ /_____

Rubella titer: Date _____/_____ /_____

**B. Tetanus, Diphtheria, Acellular Pertussis (Tdap)** — Tdap _____/_____ /_____

One dose is required for all students. (within the past ten years)

**C. Hepatitis B Vaccine: Three doses required** — Dose 1 _____/_____ /_____

**or** — Dose 2 _____/_____ /_____

Documentation of a positive antibody titer (HBsAb) (attach copy of titer) — Dose 3 _____/_____ /_____

❒ Positive ❒ Negative Date _____/_____ /_____

**D. Meningococcal Vaccine** (within the past five years) — Date _____/_____ /_____

Required for all resident students.

**E. Varicella (Chicken Pox): Two doses required** — Dose 1 _____/_____ /_____

**or** — Dose 2 _____/_____ /_____

Documentation of Varicella antibody titer (attach copy of titer)

❒ Positive ❒ Negative Date _____/_____ /_____

**or**

Documentation or reliable history of disease (chicken pox) verified by a health care provider: — Date _____/_____ /_____

**or**

❒ No documentation needed for those born before 1980

## II. PAST MEDICAL HISTORY

**Please describe any history of past medical issues, hospitalizations, medications, and allergies.**

_____

_____

_____

_____

_____

**HEALTH CARE PROVIDER**

Name (print) _____ Signature _____

Address _____ Phone _____ Fax _____

**Please include verification of the facility with a stamp of the medical practice name and address:**

# Physical Examination

**To be completed and signed by health care provider at time of examination**

Student Name _____ Date of Birth _____ Date of Exam _____

Height _____ Weight _____ Blood Pressure _____ Pulse _____

| System | Normal | Describe Abnormality |
|---|---|---|
| Skin | | |
| HEENT | | |
| Lungs/Chest | | |
| Breasts | | |
| Heart/Vascular | | |
| Abdomen (rectal if indicated) | | |
| Genito/Urinary | | |
| Pelvic (if indicated) | | |
| Lymphatic | | |
| Musculoskeletal | | |
| Neurological | | |
| Endocrine | | |
| Psychological | | |

**Lab work recommended:** Hgb/Hct _____ Cholesterol _____ Urine: Glucose _____ Protein _____ Micro _____
A1C (if applicable) _____

## Current and/or Chronic Problems

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

**Please Note:** **If student is under care for a chronic condition or serious illness, please attach additional clinical reports to assist us in providing continuity of care.**

_____

_____

## Special Dietary Requirements

_____

_____

## Current Medications (Please list all prescriptions)

_____

_____

## Athletic and Physical Activity Clearance

❒ **The applicant may participate in physical activity:**
- ❒ **Without restriction**
- ❒ **With the following restrictions:** _____

❒ **The applicant should NOT participate in physical activities because:** _____

**MAIL THIS COMPLETED FORM TO:**

Family Medicine Associates at Endicott College
376 Hale Street
Beverly, MA 01915
**Phone: 978-232-2104** **Fax: 978-998-8004**

**HEALTH CARE PROVIDER**

Name (print) _____ Signature _____

Address _____ Phone _____ Fax _____

**Please include verification of the facility with a stamp of the medical practice name and address:**

# TUBERCULOSIS RISK ASSESSMENT

**Side ONE of a two-sided form**
**Side ONE is completed by the student.**

Date _____/_____ /_____

Name of Student _____ ❒ Male ❒ Female
Last First Middle

Date of Birth _____/_____ /_____ Endicott ID# _____ Country of Birth _____
Month Day Year

**Please answer the following questions:**

1. Have you ever been in close contact with anyone sick with tuberculosis? ❒ Yes ❒ No
2. Were you born in one of the countries listed below? ❒ Yes ❒ No

   If yes, what country: _____ Date of entry into the United States _____
3. Have you lived or traveled for more than one month in one or more of the countries listed below? ❒ Yes ❒ No

   If yes, what country/ies: _____ When _____

**If you answered YES to any of the questions above, Endicott College requires you to have a tuberculin skin test (TST) to check for latent tuberculosis infection (LTBI), to be completed within six months prior to the start of classes. Your health care provider must fill out SIDE TWO of this form.**

**If you have had a positive TST in the past, you will not need another TST, but you will need a chest X-ray. Your health care provider must fill out SIDE TWO of this form.**

**If you answer NO to all of the questions above, no further testing is required. The form is complete.**

**COUNTRIES WITH HIGH RATES OF TUBERCULOSIS**
*(World Health Organization Global Tuberculosis Control. WHO Report 2006)*

| | | | | | |
|---|---|---|---|---|---|
| Afghanistan | Central African Republic | Guatemala | Malawi | Palau | Suriname |
| Algeria | Chad | Guinea | Malaysia | Panama | Syrian Arab Republic |
| Angola | China | Guinea-Bissau | Maldives | Papua New Guinea | Swaziland |
| Anguilla | Colombia | Guyana | Mali | Paraguay | Tajikistan |
| Argentina | Comoros | Haiti | Marshall Islands | Peru | Tanzania-UR |
| Armenia | Congo | Honduras | Mauritania | Philippines | Thailand |
| Azerbaijan | Congo DR | India | Mauritius | Poland | Timor-Leste |
| Bahamas | Cote d'Ivoire | Indonesia | Mexico | Portugal | Togo |
| Bahrain | Croatia | Iran | Micronesia | Qatar | Tokelau |
| Bangladesh | Djibouti | Iraq | Moldova-Rep | Romania | Tonga |
| Belarus | Dominican Republic | Japan | Mongolia | Russian Federation | Tunisia |
| Belize | Ecuador | Kazakhstan | Montenegro | Rwanda | Turkey |
| Benin | Egypt | Kenya | Morocco | St. Vincent & Grenadines | Turkmenistan |
| Bhutan | El Salvador | Kiribati | Mozambique | Sao Tome & Principe | Tuvalu |
| Bolivia | Equatorial New Guinea | Korea-DPR | Myanmar | Saudi Arabia | Uganda |
| Bosnia & Herzegovina | Eritrea | Korea-Rep | Namibia | Senegal | Ukraine |
| Botswana | Estonia | Kuwait | Nauru | Seychelles | Uruguay |
| Brazil | Ethiopia | Kyrgyzstan | Nepal | Sierra Leone | Uzbekistan |
| Brunei Darussalam | Fiji | Lao PDR | New Caledonia | Singapore | Vanuatu |
| Bulgaria | French Polynesia | Latvia | Nicaragua | Solomon Islands | Venezuela |
| Burkina Faso | Gabon | Lesotho | Niger | Somalia | Vietnam |
| Burundi | Gambia | Liberia | Nigeria | South Africa | Wallis & Futuna Islands |
| Cambodia | Georgia | Lithuania | Niue | Spain | West Bank & Gaza Strip |
| Cameroon | Ghana | Macedonia-TFYR | Northern Mariana Island | Sri Lanka | Yemen |
| Cape Verde | Guam | Madagascar | Pakistan | Sudan | Zambia |
| | | | | | Zimbabwe |

# TUBERCULOSIS RISK ASSESSMENT

**Side TWO of a two-sided form**
**When applicable, Side TWO is completed by the student's health care provider.**

## TUBERCULIN SKIN TEST (TST)

**Plant Date** _____/_____ /_____ **Read Date** * _____/_____ /_____ *(* 48–72 hours after plant date)*

**Result** ** _____ mm of induration *(** If no induration, write "0." See interpretation guidelines below.)*

❒ Negative ❒ Positive If positive, continue below.

## IF POSITIVE TUBERCULIN SKIN TEST (now or by history) THE FOLLOWING ARE REQUIRED

**Date of Positive TST** _____/_____ /_____ **Result** _____ mm of induration

**Date of Chest X-ray** _____/_____ /_____ ❒ Normal ❒ Abnormal (Please attach report, NOT the X-ray)

**Clinical Evaluation** ❒ Normal ❒ Abnormal
Describe _____

**Treatment** ❒ No ❒ Yes
If yes, drug/s, dose, frequency, and dates _____
_____

## HEALTH CARE PROVIDER

Health Care Provider's Signature _____

Name of Health Care Provider (please print) _____

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Phone (_____) _____ FAX (_____) _____

| | ** **Interpretation Guidelines** | |
|---|---|---|
| **5 mm or greater is positive:**<br>• Recent close contacts of an individual with infectious TB<br>• Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease<br>• Organ transplant recipients<br>• Immunosuppressed persons: taking >15 mg/d of prednisone for > 1 month; taking a TNF-α antagonist<br>• Persons with HIV/AIDS | **10 mm or greater is positive:**<br>• Persons born in a high prevalence country or who resided in one for a significant amount of time<br>• History of illicit drug use<br>• Mycobacteriology laboratory personnel<br>• History of resident, worker or volunteer in high-risk congregate settings<br>• Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes | **15 mm or greater is positive:**<br>• Persons with no known risk factors for TB disease |