



Tel: 978-232-2104 • Fax: 978-998-8004 • Email: fma@endicott.edu

Health Form 2021–22

(Beverly Campus)

PLEASE NOTE: ALL STUDENTS must see that this form is completed, signed, and returned to the Health Center no later than August 1, 2021 for fall semester or January 15, 2022 for spring semester.

Mail to: Health Center 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 or attending classes.

We recommend that you make and keep a copy of this form for your records.

Your health information is private and protected by state and federal law. Endicott College is dedicated to protecting your rights.

Instructions for Completing All Necessary Health Forms

Health Form Sections

- The student fills out the Student Information section. Please print clearly.
- Your health care provider 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.
- As a COVID-19 Vaccination is required for all Endicott students, the student or a health care provider must submit a COVID-19 vaccination card or proof of vaccination

Tuberculosis Screening Questionnaire

- The Tuberculosis Screening Questionnaire is a two-sided form. (The student fills out Part I, and if he or she answers "no" to all of the risk questions, there is no need to fill out Part II.)
If the answer to any of the questions is "yes," the student's health care provider must complete Part II.

Information on Meningococcal Disease

The form titled Information about Meningococcal Disease, Meningococcal Vaccines, Vaccination Requirements, and the Waiver for Students at Colleges and Residential Schools is a separate document from this Health Form. It explains that all newly enrolled full-time students 21 years of age and younger AND all students living in campus housing must have had a dose of quadrivalent meningococcal vaccine within the past five years or must complete the waiver form.

If you misplace the forms, additional forms can be accessed on the Endicott College Health Center web page at endicott.edu/orientation. If you have any questions or concerns, please contact the Health Center at Endicott College at 978-232-2104 or fma@endicott.edu.

For Athletes Only

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):

For Nursing Majors Only

All nursing majors must make **two** copies of this entire form and send one to the School of Nursing and **one** to the Health Center.

Student Affairs
Endicott College
978-232-2206
orientation@endicott.edu

Tammy Medros, *Site Coordinator*
Health Center at Endicott College
978-232-2104
fma@endicott.edu

Student Information

To be completed by student. Please print clearly.

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 the Health Center 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 _____

Telephone Numbers: home (____) _____ business (____) _____ cell (____) _____

Name _____ Relationship to Student _____

Permanent Street Address _____

City _____ State _____ Zip Code _____

Telephone Numbers: home (____) _____ business (____) _____ cell (____) _____

Consent for Emergency Treatment

To be signed by parent/guardian if student is under 18 years of age

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.

If you plan to enroll in the College-sponsored plan, please write "Endicott College Insurance" for the Insurance Company, and leave the rest blank.

For Students Seeking Accommodations

(Physical, Psychological, or Learning)

Please notify the Center for Accessibility Services at 978-232-2927 or access@endicott.edu

Staff members there can discuss your needs and requests with you.

Medical & 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)

One dose is required for all students. (within the past 10 years)

Tdap ____/____/____

C. Hepatitis B Vaccine: Three doses required

Dose 1 ____/____/____

Dose 2 ____/____/____

Dose 3 ____/____/____

or

Documentation of a positive antibody titer (HBsAb) (attach copy of titer)

Positive Negative Date ____/____/____

D. Meningococcal (Quadrivalent) Vaccine (administered after age 16 and within the past five years)

Required for all resident students AND all new full-time students 21 years of age and younger

Date ____/____/____

E. COVID-19 Vaccination (include a copy of your vaccination card)

Dose 1 ____/____/____

Dose 2 ____/____/____

F. Varicella (Chicken Pox): Two doses required

or

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:

or

No documentation needed for those born before 1980

Dose 1 ____/____/____

Dose 2 ____/____/____

G. Influenza (Flu Vaccine)

Date ____/____/____

II. REQUIRED IMMUNIZATIONS FOR ATHLETIC TRAINING MAJORS

Month / Day / Year

A. Tuberculosis PPD test within the last six months

Date ____/____/____

PPD result _____ If positive, X-Ray result _____

Is patient currently on medication? No Yes _____

III. 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 &/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 & 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: Health Center 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 (TB) Screening Questionnaire

Name of Student _____ Endicott ID # _____

Last
First
Middle

Student Signature _____

PART I

To be completed by the student

Please answer the following questions:

1. Have you ever had close contact with persons known to have or suspected of having active TB? Yes No
2. Were you born in one of the countries or territories listed below that have a high incidence of active TB? Yes No
 If yes, please CIRCLE the name of the country or territory in the list below.
3. Have you had visits of one month or more to any of the countries or territories listed below that have a high prevalence of TB? Yes No
 If yes, please CIRCLE the name of the country or territory in the list below.

Countries with High Rates of Tuberculosis

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2014. Countries with incidence rates of ≥ 20 cases per 100,000 population

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

Please Note:

If the answer to any of the above questions is “yes,” Endicott College requires that you receive TB testing as soon as possible, but at least prior to the start of the subsequent semester. In addition, your health care provider must complete Part II of this form (on reverse side).

If the answer to all of the above questions is “no,” no further testing and no further action is required.

PART II

Clinical Assessment by Health Care Provider

Persons answering YES to any of the questions in Part I are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented.

History of a positive TB skin test or IGRA blood test? (If yes, document below) Yes No

History of BCG vaccination? (If yes, consider IGRA if possible.) Yes No

1. Tuberculosis Symptom Check

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

2. Tuberculin Skin Test (TST)

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0"
The TST interpretation should be based on mm of induration as well as risk factors. **

Date Given ____/____/____

Date Read ____/____/____

Result _____ mm of induration

Interpretation ** Negative Positive

Date Given ____/____/____

Date Read ____/____/____

Result _____ mm of induration

Interpretation ** Negative Positive

**** Interpretation Guidelines**

<p>5 mm or greater is positive:</p> <ul style="list-style-type: none"> Recent close contacts of an individual with infectious TB Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of > 15 mg/d of prednisone for > 1 month) HIV-infected persons 	<p>10 mm or greater is positive:</p> <ul style="list-style-type: none"> Recent arrivals to the U.S. (<5 years) from high prevalence areas or who resided in one for a significant amount of time Injection drug users Mycobacteriology laboratory personnel Residents, employees, or volunteers in high-risk congregate settings Persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemias and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight 	<p>15 mm or greater is positive:</p> <ul style="list-style-type: none"> Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested
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3. Interferon Gamma Release Assay (IGRA)

Proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest X-ray, and sputum evaluation as indicated.

Date Obtained ____/____/____

Specify method: QFT-GIT T-Spot Other _____

Result Negative Positive

Indeterminate Borderline (T-Spot only)

Date Obtained ____/____/____

Specify method: QFT-GIT T-Spot Other _____

Result Negative Positive

Indeterminate Borderline (T-Spot only)

4. Chest X-ray: (Required if TST or IGRA is positive)

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0"
The TST interpretation should be based on mm of induration as well as risk factors. **

Date of X-ray ____/____/____

Result Normal Abnormal

Student agrees to receive treatment Student declines treatment at this time

Name of Health Care Provider (please print) _____

Health Care Provider's Signature _____

Street Address _____

City _____ State _____ Zip Code _____ Country _____

Phone _____ Fax _____