

## Health Form 2026–2027

(Beverly Campus)

**PLEASE NOTE: ALL STUDENTS must complete this form by uploading (mailed forms will not be accepted) it to Workday no later than July 1, 2026 for fall semester or January 4, 2027 for spring semester. Any student failing to do so will be prohibited from residing on campus or attending classes.**

*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.

#### 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](http://endicott.edu/orientation). If you have any questions or concerns, please contact the Health Center at Endicott College at 978-232-2104 or [wellness@endicott.edu](mailto:wellness@endicott.edu).

**For Student-Athletes only:**

**All student-athletes must complete this form; upload one to Sportsware for the Division of Athletic Training and upload one to Workday.**

Endicott Varsity or Club Team(s):

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# 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 the 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](mailto:access@endicott.edu).

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

# Medical & Immunization History

To be completed and signed by a 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 the serology titer is done, please attach a copy of the 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 10 years).

### 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)

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

### F. Varicella (Chicken Pox): Two doses required

Dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

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 healthcare provider: 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 a 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		
<b>Lab work recommended:</b> Hgb/Hct _____ Cholesterol _____ Urine: Glucose _____ Protein _____ Micro _____ A1C (if applicable) _____		

**Current &/or Chronic Problems**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**PLEASE NOTE:** If a 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: \_\_\_\_\_

**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.



**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

<b>** Interpretation Guidelines</b>		
<p><b>5 mm or greater is positive:</b></p> <ul style="list-style-type: none"> <li>•Recent close contacts of an individual with infectious TB</li> <li>•Persons with fibrotic changes on a prior chest X-ray consistent with past TB disease</li> <li>•Organ transplant recipients and other immunosuppressed persons (including receiving equivalent of &gt; 15 mg/d of prednisone for &gt; 1 month)</li> <li>•HIV-infected persons</li> </ul>	<p><b>10 mm or greater is positive:</b></p> <ul style="list-style-type: none"> <li>•Recent arrivals to the U.S. (&lt;5 years) from high prevalence areas or who resided in one for a significant amount of time</li> <li>•Injection drug users</li> <li>•Mycobacteriology laboratory personnel</li> <li>•Residents, employees, or volunteers in high-risk congregate settings</li> <li>•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 jejunioileal bypass and weight loss of at least 10% below ideal body weight</li> </ul>	<p><b>15 mm or greater is positive:</b></p> <ul style="list-style-type: none"> <li>•Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested</li> </ul>

**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 \_\_\_\_\_