ENDICOTT COLLEGE
376 HALE STREET • BEVERLY, MASSACHUSETTS 01915

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

Health Form 2019–20

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 1, 2019 FOR FALL SEMESTER OR JANUARY 15, 2020 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.

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) _____

Stephen Sweet, Associate Dean of Students
Endicott College
978-232-2113
ssweet@endicott.edu

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

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.

Name of Student _____ Endicott ID# _____

Last First Middle

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		
5 mm or greater is positive: • 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	**10 mm or greater is positive:** • 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	**15 mm or greater is positive:** • Persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested

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 _____

Prepared originally by the American College Health Association's Tuberculosis Guidelines Task Force;
Revised April 2016 by Emerging Public Health Threats and Emergency Response Coalition