

# Medical History, Physical Examination and Immunization Form

## Western New England College Health Services

1215 Wilbraham Road, Springfield, MA 01119

Phone 413-782-1211 Fax 413-796-2255

For fall registration return to Health Services prior to August 1 or for alternate registration times, within 14 days of notification

Information you provide will be used solely by Health Services as an aid to providing health care.

**Students please complete demographic and health history sections before going to your health care provider..**

NAME LAST	FIRST	MIDDLE	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
DATE OF BIRTH (MM-DD-YY)	SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER
ADDRESS – HOME	CITY	STATE	COUNTRY ZIP
EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE NUMBER	WORK OR CELL PHONE NUMBER
ALLERGIES TO MEDICATIONS		ALLERGIES? OTHER (i.e., food, latex, tape, environmental)	
MEDICATIONS? PRESCRIPTIONS YOU ARE TAKING (specify dosage)		OTHER MEDICATIONS (over the counter, supplements, vitamins)	
HEALTH SITUATIONS OR DISABILITIES YOU WISH HEALTH SERVICES TO BE AWARE OF: (asthma, epilepsy, diabetes, etc.)			

### PERSONAL HISTORY: PLEASE CHECK ANY THAT APPLY TO YOU

Explain positives in space provided

Abnormal Bleeding	Depression	Hepatitis	Scoliosis
Anemia	Diabetes	Heat stroke/Sun stroke	Seizures
Anxiety	Disability	Hernia	Sickle cell trait
Arthritis	Ear trouble/Hearing loss	High Blood Pressure	Single organ
Asthma	Eating disorder	High cholesterol	Sinus trouble
ADD/ADHD	Eye trouble/Visual loss	Intestinal/Stomach trouble	Spleen (Surgical removal)
Cancer	Fractures (including stress)	Joint injury (sprain/dislocation)	Syncope/Fainting
Chest pain	Genetic disorder	Kidney disease	Thyroid disease
Chicken pox	Headaches (recurrent)	Mononucleosis	Tobacco use
Concussion/Head injury	Heart murmur	Orthopedic problem (chronic)	Tuberculosis
Convulsive disorder	Heart problems (other)	Rheumatic fever	Other

### Operations (include month and year):

FAMILY HISTORY	Age(s)	State of Health	If Deceased, Age and Cause
Father			
Mother			
Brothers/ Sisters			

**CONSENT FOR TREATMENT** In case of serious illness or accident, I give Western New England College Health Services or its representative(s) permission to secure medical and/or surgical care deemed necessary for my good health. I authorize Health Services to perform medical care and immunizations as deemed necessary by licensed personnel. Also, I have read the Notice of Privacy Practices (HIPAA) disclosing how Western New England College Health Services may use and disclose my protected health information.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Parent/Guardian Signature (only if student is under 18)

\_\_\_\_\_  
Date

## PHYSICAL EXAMINATION

**To the examining health care provider:** Please review the student's history and complete the information below and on page 2

Sex: M  F  BP: \_\_\_/\_\_\_ Height \_\_\_ Weight \_\_\_ Urine: Sugar \_\_\_ Albumin \_\_\_ Hgb or Hct \_\_\_

*The Commonwealth of Massachusetts Immunization Law requires proof of the following immunizations:*

1 Tetanus-Diphtheria Booster: (within the past 10 years).....Month/Day/Yr \_\_\_\_\_

2 MMR (Measles, Mumps and Rubella, if given instead of individual immunizations, 2 doses required)

Dose 1 (on or after the first birthday) Month/Day/Yr \_\_\_\_\_

Dose 2 (at least 1 month after the first) Month/Day/Yr \_\_\_\_\_

OR

Student's Name \_\_\_\_\_

Measles immunizations: (If given instead of MMR, 2 doses required)

Dose 1 (on or after the first birthday)

Month/Day/Yr \_\_\_\_\_

Dose 2 (at least 1 month after the first)

Month/Day/Yr \_\_\_\_\_

1 Mumps immunization: (on or after the first birthday)

Month/Day/Yr \_\_\_\_\_

1 Rubella immunization: (on or after the first birthday)

Month/Day/Yr \_\_\_\_\_

Hepatitis B Vaccine #1

Month/Day/Yr \_\_\_\_\_

Hepatitis B Vaccine #2 (at least 30 days after the first dose)

Month/Day/Yr \_\_\_\_\_

Hepatitis B Vaccine #3 (5 months after the second dose)

Month/Day/Yr \_\_\_\_\_

Meningococcal vaccine (undergraduates at entrance to college or within the last 5 years) Month/Day/Yr \_\_\_\_\_

I would like to receive the meningitis vaccine in Health Services and understand that \$110 will be placed on my tuition bill and I will be provided a receipt which I may submit to my insurance company for reimbursement if covered \_\_\_\_\_

Student's Initials \_\_\_\_\_

Three doses of Human Papillomavirus Vaccine (Gardasil) are **strongly recommended** for all females students

Month/Day/Yr \_\_\_\_\_ Month/Day/Yr \_\_\_\_\_ Month/Day/Yr \_\_\_\_\_

Please answer the following Tuberculosis risk questions 1. Have you ever had close contact with anyone sick with TB?  Yes  No  
Were you born in or lived for more than 1 month in any foreign country?  Yes  No

**If proof of immunization for a measles, mumps, rubella or Hepatitis B is not available blood titer immunity will be accepted**

Measles/ Mumps/Rubella Titer drawn Month/Day/Yr \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Actual Titer Value \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Hepatitis B Surface Antibody drawn Month/Day/Yr \_\_\_\_\_ Actual Titer Value \_\_\_\_\_

Are there any abnormalities of the following systems or impaired function of any organ? Use additional sheets as needed

	YES	NO
1. Skin, Blood		
2. Eyes, Head, Ear, Nose, Throat		
3. Respiratory		
4. Cardiovascular		
5. Gastrointestinal		
6. Hernia		
7. Genitourinary		
8. Musculoskeletal		
9. Metabolic/Endocrine		
10. Neurological/Psychiatric, Seizure, etc.		
11. Other significant physical abnormality or deficit		

If answer is "yes" to any of the above, explain: \_\_\_\_\_

IS THERE ANY REASON THIS STUDENT SHOULD NOT PARTICIPATE IN CONTACT SPORTS?  Yes  No

If "yes", explain: \_\_\_\_\_

Do you have any recommendations regarding the care of this student?  Yes  No

Specify: \_\_\_\_\_

Is the patient now under treatment for emotional or psychological conditions?  Yes  No

Specify: \_\_\_\_\_

Print or Stamp

Name \_\_\_\_\_ **Date Physical Exam Completed** \_\_\_\_\_  
(Must be within 6 months of semester start for Athletes/ 1 year for non-athletes)

Address \_\_\_\_\_

Telephone and Fax \_\_\_\_\_

Signature \_\_\_\_\_  MD  DO  NP  PA Date \_\_\_\_\_