SPRINGFIELD COLLEGE HEALTH CENTER
263 Alden Street / Springfield, Massachusetts 01109
(413) 748-3175 / (413) 748-3444 (fax)
healthcenter@springfieldcollege.edu

Please do not submit partially completed forms

Health requirements are only considered fulfilled when all **three** pages have been successfully completed.

HEALTH FORM

Forms are due no later than December 15th for spring entry, April 15th for summer entry and July 15th for fall entry
PLEASE NOTE: Full clearance for registration **WILL NOT** be granted until **ALL** health requirements have been met.

Name (last, first, middle):		**Identified Gender:** ☐ Male ☐ Female
Date of Birth:	**Student ID:**	**Email:**
Address:	**City/State/Zip Code:**	
Telephone Numbers: Home:	Cell:	

EMERGENCY CONTACT

Name:	Relationship:	Home Phone:	Alternate Phone:

ALLERGIES

Medication Allergies:
Other Allergies:

CURRENT MEDICATIONS:

Name of Medication	Dosage and Schedule
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

PERSONAL HISTORY

Have you ever had:	YES	NO		YES	NO		YES	NO
Anemia			Ear/Hearing Disorder			High Cholesterol		
Asthma			Eye/vision Disorder			Hospitalizations/Surgeries		
Bleeding Disorder			Eating Disorder			Joint/Bone Disease		
Cancer			Gastrointestinal Disease			Mental Illness		
Chicken Pox (Varicella)			Head Injury/Concussions			Mononucleosis		
Diabetes			Heart Disease			Tobacco Use		
Dizziness/Fainting			High Blood pressure			Other		

INCLUDE DATE/YEAR, DESCRIPTION, AND COMPLICATIONS FOR EACH "YES." Use separate page if needed.

____
____
____

FAMILY HEALTH STATUS

	Age	State of Health	Significant Illnesses
Father			
Mother			
Sibling(s)			

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

______________________________________ ______________________

STUDENT SIGNATURE **DATE**

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PHYSICAL EXAMINATION and TUBERCULOSIS QUESTIONNAIRE

Admission requirement: Physical exam on or after September 1st 2016 (2 years)

NCAA athletes: Please note that NCAA requires physical examination within 6 months for sports clearances

Student's Name: ______________________________ **Date of Birth**:______________

Height: __________ **Weight:** __________ **Blood Pressure:** __________ **Pulse:** __________

PHYSICAL EXAMINATION	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
General			
Skin			
HEENT			
Neck/Thyroid			
Chest and Lungs			
Cardiovascular			
Abdomen			
Genitals/Hernia			
Neurological			
Musculoskeletal			
Lymph			

TUBERCULOSIS RISK ASSESSMENT:

Low Risk Screen:
- Has the patient had close contact with someone with TB? YES ☐ NO ☐
- Was the patient born outside of the United States? YES ☐ NO ☐
- Has the patient lived for more than one month outside of the United States? YES ☐ NO ☐

If yes to any assessment question please download and complete TB screening form

PROVIDER RECOMMENDATIONS:

- Is this individual currently under treatment for any medical or emotional condition? YES ☐ NO ☐
  - If **YES**, please specify: ______________________________
- Do you have any recommendations regarding the care of this individual? YES ☐ NO ☐
  - If **YES**, please specify: ______________________________
- Recommendation for physical activity: Unlimited ☐ Limited ☐
  - If **LIMITED**, please specify: ______________________________

Provider Signature: ______________________________ **Date of Exam**: __________

Printed Name: ______________________________

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Health Entrance Immunization Record

Name: ____________________________ **Date of Birth:** ___________ **Student ID:** ____________

Massachusetts State law requires **all full time college students and all full or part time health science students** submit documentation of the following vaccinations.

Please provide dates of vaccinations**

Required Immunizations Provide dates	**Immunization Dates*** **(M/D/YR)**			
Hepatitis B 3 Doses	On/after 1st birthday / /	≥4 wks after 1st dose / /	≥4 months after 2nd dose / /	
MMR (Measles, mumps and rubella) 2 doses	On/after 1st birthday / /		≥4 wks after 1st dose / /	Student born before 1957 are not required to complete MMR documentation.
Tdap (tetanus, diphtheria, and pertussis) - 1 dose	On or after 7th birthday / /			If your Tdap vaccine is >10 years old a Td booster is recommended
Varicella 2 doses OR History of disease	On/after 1st birthday / /	≥4 wks after 1st dose / /	**OR** **Date of history of disease / /	Students born before 1980 are not required to complete varicella documentation
Meningococcal 1 dose of conjugate or 1 dose of polysaccharide	/ /	All students under 21 years of age must have meningitis vaccination on or after their 16th birthday regardless of housing status		Students over the age of 21 who are not living in college owned housing may complete meningitis waiver documentation

**If dates of vaccinations are not available you may attach lab reports of titer results

FAILURE TO COMPLY WITH MASSACHUSETTS IMMUNIZATION LAW WILL RESULT IN A HOLD ON YOUR REGISTRATION

Health Care Provider's Signature: ____________________________________ **Date:** ____________

Printed Name: ____ MD/DO/PA/NP

Address: ____

Telephone: _________________________________ **Fax:** _______________________