Health Services provided by Newton-Wellesley Collegiate Health

**NEW STUDENT HEALTH FORM**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_ Gender Identity/preferred pronouns:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***To be filled out with your Health Care Provider. Attach additional pages if needed.***

Do you have any past/current medical diagnoses: \_\_\_\_ YES \_\_\_\_ NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you have any past/current mental health diagnoses: \_\_\_\_ YES \_\_\_\_ NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized? \_\_\_\_ YES \_\_\_\_ NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had surgery? \_\_\_\_ YES \_\_\_\_ NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently see any specialists (including therapists, nutritionist, etc.)? \_\_\_\_ YES \_\_\_\_ NO

If yes, please list specialty and contact information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications that you currently use, including IUD, over the counter, Epi Pen. Please include the dose and indication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any allergies and your reaction:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you regularly used alcohol or other substances including tobacco/nicotine, marijuana, or illicit drugs? \_\_\_\_ YES \_\_\_\_ NO

If yes, please indicate type, amount, and quit date (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any pertinent family history (including medical and/or mental health diagnoses):

Parent/s (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sibling/s (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if adopted or unknown medical history □

Date of last Physical (must be within 1 year of matriculation, 6 months for athletes): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_ Weight: \_\_\_\_\_\_ BMI: \_\_\_\_\_\_ Pulse: \_\_\_\_\_\_ BP: \_\_\_\_\_ /\_\_\_\_\_ Vision: R 20/\_\_\_\_ L 20/\_\_\_\_

Please describe abnormalities on complete physical exam:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check if exam normal □

Recommendation for activity: \_\_\_\_ UNLIMITED\_\_\_\_ LIMITED

If limited, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS**

The below chart must be filled out. \*REQUIRED\* immunizations must be included. Please attach titer results if applicable.

|  |  |
| --- | --- |
| Vaccine | Date (MM/DD/YYY) received OR attached positive titer result |
| COVID-19 *Requirement subject to change* | Dose 1: \_\_\_/\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_/\_\_\_/\_\_\_\_\_Brand: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hepatitis A | Dose 1: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_□ Positive titers attached □ Unable to access |
| **Hepatitis B \*REQUIRED\*** | Dose 1: \_\_\_ /\_\_\_ /\_\_\_\_\_   Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 3 (if indicated): \_\_\_ /\_\_\_/\_\_\_\_\_□ Positive titers attached □ Unable to access |
| Human Papillomavirus | Dose 1: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 3 (if 1st dose received on or after 15th birthday): \_\_\_ /\_\_\_ /\_\_\_\_\_ |
| **Influenza \*REQUIRED\* *after August 1st annually*** | Annual dose: \_\_\_ /\_\_\_ /\_\_\_ □Unable to access |
| **Measles, Mumps, Rubella (MMR) \*REQUIRED\*** | Dose 1 (on or after 1st birthday): \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_□ Positive titers attached □ Unable to access |
| Meningitis B | Dose 1: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 3 (when indicated) \_\_\_ /\_\_\_ /\_\_\_\_\_ |
| Meningococcal (ACYW) or *State of MA Meningococcal Vaccine Waiver must be signed and attached* | Most recent dose received *on/after 16th birthday*:\_\_\_ /\_\_\_ /\_\_\_\_\_□ Waiver attached  |
| **Tetanus-Diptheria and Pertussis \*REQUIRED\*** | Most recent dose within the past 10 years: \_\_\_ /\_\_\_ /\_\_\_\_\_  □ Unable to access  |
| **Varicella \*REQUIRED\*** | Dose 1: \_\_\_ /\_\_\_ /\_\_\_\_\_ Dose 2: \_\_\_ /\_\_\_ /\_\_\_\_\_□ Positive titers attached □ Unable to access |
| Other (specify, *include BCG vaccine if received*): |  |

**Tuberculosis Screening – part 1**

*For a list of the countries with the highest burden of TB, refer to this link: http://www.stoptb.org/countries/tbdata.asp*

|  |  |  |
| --- | --- | --- |
| Have you ever had close contact with persons known or suspected to have active TB disease, or at increased risk for TB? This includes working/volunteering/ living in high risk settings (including healthcare and with medically underserved populations, long term care, correctional facilities, homeless shelters, low income, abusing drugs or alcohol) | YES  | NO |
| Were you born in OR arrived in the U.S. within the past 5 years from OR had frequent or prolonged visits (<1 month) to a country/ territory with high incidence of active TB? If yes, please list: | YES | NO |

If the answer to the above questions is NO, no further TB testing is required- please sign below.

If you answered YES to either of the above, please continue to part 2 of the TB screening on Page 3.

*I certify that the information provided is complete and accurate*

Health Care Provider: Please print Last name, First name, and title (DO, MD, NP, PA)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_

Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

**TB screening – part II if indicated**

Does the student have any signs or symptoms of TB? \_\_\_\_ YES \_\_\_\_ NO

*Symptoms of TB include cough w or w/o sputum production, hemoptysis, chest pain, loss of appetite, unexplained weight loss, night sweats, fever.*

If the answer to any of the TB screening questions is yes, proceed with appropriate testing (below). Testing must be done within 1 year of matriculation.

|  |  |
| --- | --- |
| □ Mantoux tuberculin skin test (TST)Date Given (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date Read (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result (mm induration): \_\_\_\_\_ Interpretation: □ positive □ negative | □ Interferon Gamma Release Assay (IGRA)Date Obtained (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Method: □ QuantiFERON-Gold □ T-SpotInterpretation: □ positive □ negative |

Has the student ever had a positive TST or IGRA?\_\_\_\_ YES \_\_\_\_ NO If yes, please note date of positive test: \_\_\_\_\_\_\_

If patient is symptomatic AND/OR tests positive on TST or IGRA, a CHEST X-RAY IS REQUIRED and copy must be attached

|  |
| --- |
| Date of Chest X-ray (MM/DD/YYYY): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Result: □ NORMAL □ ABNORMAL (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

All students with a positive TST or IGRA with no signs of active disease on chest x-ray should receive a recommendation to be treated for latent TB. If applicable: Date of and treatment for LTBI:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I certify that the information provided is complete and accurate*

Health Care Provider: Please print Last name, First name, and title (DO, MD, NP, PA)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Signature of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_