OFFICE USE ONLY

@ ___________________ NAME: ______________________________

Entering Semester: ____________________ Banner Complete: Yes / No

Letter sent/missing: ______________________ (complete now: Yes / No)

FITCHBURG STATE COLLEGE

STUDENT HEALTH FORM

Student Health Services **160 Pearl Street** **Fitchburg, MA 01420** **978/665-3216**

Major: ___________________________ Transfer ☐ Yes ☐ No Due Date: ________________

All full-time undergraduate, and graduate students are required to complete this form.

You and your parents must complete pages one, two and the top of page three. Your Healthcare Practitioner should verify your medical history, sign the bottom of page two, and complete pages three and four. This form is the basis of your medical record and remains confidential.

Name: ____ Date of Birth: _______________________
Last First Middle

Student ID#: ____ ☐ Male ☐ Female ☐ Transgender Marital Status: _____________

Home Telephone: ____ Cell Phone: ____

Home Address (Street or P.O. Box): ____

Town: ____ State: __________ Zip code: _______________ Country: _____________________

Parent(s)/ Guardian/Partner Name: ____ Relationship: _______________________

Address: ____ Telephone: _______________________

Business Address: ____ Telephone: _______________________

Parent(s) are: ☐ Married ☐ Living with Domestic Partner ☐ Widowed ☐ Divorced ☐ Separated

Alternate responsible person residing at different address from above to be contacted in case of emergency if parent/guardian/spouse/partner is unavailable.

Name: ____ Phone: _______________________

Address: ____ Relationship: _______________________

Insurance

Insurance is required for all full time students. Student should carry an insurance card.

Will you be enrolled in the Student Health Insurance plan? ☐ Yes ☐ No

If no, under what insurance will you be covered? ____

Insurance address/phone: ____ Certificate #: _______________________

Subscriber's Name: ____ Relationship: _______________________

Consent for treatment (required)

Students under 18

I hereby give consent for my minor child, to receive routine care through the Fitchburg State College Student Health Services.

Signature: ____ Print name: ____
Parent or Guardian Parent or Guardian

Student Health History

Check at right of each item. If "yes", explain as appropriate. All items require a “yes” or “no” response.

Explain any "yes" answers at bottom, attach a separate sheet, if necessary.

	Yes	No		Yes	No
Hospitalization (date, reason)			**Have you ever had**		
			Migraines (diagnosed by MD)		
			Epilepsy/convulsions		
Operation (date, reason)			Paralysis or disability		
			Thyroid problems		
			High blood pressure		
			Rheumatic fever		
Serious accident			Heart murmur (diagnosed by MD)		
Serious illness			Mitral valve prolapse		
Emotional problem			Asthma		
Psychiatric treatment			Colitis/ileitis		
Other significant health problems (specify)			Irritable bowel		
Communicable Diseases (give dates)			Hepatitis		
Chicken pox			Kidney disease		
Malaria			Back problems		
Tuberculosis			Recurrent depression		
Other (specify)			Anorexia/Bulimia		
Do you have an Allergy to:			High cholesterol		
Penicillin			Mono (diagnosed by MD)		
Other antibiotics (specify)			Diabetes		
Other medications (specify)			Exposure to Estrogen (DES) before birth		
Life threatening reaction to insect bites, food, etc.			**Current health problems**		
Do you carry epinephrine (Epi-pen)? (explain)			Are you currently in psychiatric counseling?		
Do you currently take: (list at bottom of page)			Do you have a chronic disease? (identify)		
Heart/blood pressure medications			Physical disability (type)		
Tranquilizers			Learning disability		
Insulin			Visual impairment (describe)		
Antidepressants			Hearing loss		
Allergy injections (see information sheet)			Hearing aid		
Ritalin			Crutches, braces, or other prosthesis		
Birth Control Pills			Loss of paired organ (i.e., one eye, one kidney) (which organ? which side?)		
Other (specify)					
Lifestyle			Are you presently under treatment for any medical problem? (describe)		
Alcohol (ounces per week)					
Illicit Drugs			Medications you expect to be continuing when you come to Fitchburg State (list)		
Do you/have you smoked? Cigarettes per day/years smoking					
Do you diet frequently?					
Do you exercise regularly?					
Do you wear a seatbelt?			Have you been immunized with 3 doses of Gardasil?		
Special diet restrictions (specify)					

NOTE: Providers—please review with patient and provide (or attach) any pertinent medical information.

Healthcare Provider—please review and sign: ____

Family History

	Age	State of Health	Occupation	Year & Cause of Death	Details/Comments
Parent					
Parent					
Brothers					
Sisters					
Grandmother					
Grandfather					
Grandmother					
Grandfather					

Have you or any of your relatives had any of the following?

	Yes	No	Relationship		Yes	No	Relationship
Arthritis				Heart attack before 60			
Asthma, allergy, hay fever				Heart disease			
Bleeding disorder				Nervous muscular disorder			
Breast cancer				Stomach disease			
Diabetes				Stroke			
Epilepsy, convulsions				Tuberculosis			
Emotional disorder				Other			

Immunizations—Required by ALL students

To be completed by Healthcare Practitioner (dates must include month, day, and year)

Tetanus-Diptheria

- ☐ Completed primary series of tetanus-diptheria immunizations.
- ☐ Received tetanus-diptheria booster within the last ten (10) years.

Month Day Year

M.M.R. (Measles, Mumps, Rubella)

- ☐ Dose 1—immunized at 12 months or after
- ☐ Dose 2—immunized at least one month after dose 1

Month Day Year

Measles (Rubeola)—If given instead of M.M.R.

- ☐ Immunized at least 12 months after birth or later.
- ☐ Dose 2—immunized at least one month after dose 1.
- ☐ **Attach copy** of dated immune titer.

Month Day Year

Rubella—If given instead of M.M.R.

- ☐ Immunized with vaccine at 12 months after birth or later
- ☐ **Attach copy** of dated immune titer.

Month Day Year

Mumps—If given instead of M.M.R.

- ☐ Immunized with vaccine at 12 months after birth or later.
- ☐ **Attach copy** of dated immune titer.

Month Day Year

Immunizations—Required for All Students

Hepatitis B Vaccine

Vaccine dates

- ☐ Test for Immunity (required for **nursing students**) **Attach copy** of dated immune titer.

Dose 1

Dose 2

Dose 3

Month Day Year

Meningococcal Vaccine

- ☐ Vaccine Date
- ☐ Signed Waiver attached

Month Day Year

Immunizations—Required if condition 1 or 2 below is true

Tuberculosis: PPD (Mantoux)

1. **Required yearly for all Nursing Students**
2. Required if you answered "yes" on TB Risk Questionnaire

Month Day Year

- ☐ Result: ____________________________ mm
- ☐ CXR: (within 1 year) Attach copy ____________ + ___________ -

If the student has had a positive tuberculin test, did he or she complete prophylactic medication? ☐Yes ☐No

(*PPD required regardless of prior BCG inoculation)

Immunizations—Recommended for all students

Varicella Vaccine (Chicken Pox)

- ☐ History of disease
- ☐ Test of immunity: Varicella antibody. **Attach copy** of dated immune titer.
- ☐ Vaccine dose 1
- ☐ Vaccine dose 2

Month Day Year

Healthcare Provider—please review and sign: ______________________________

Physical Examination

The FSC athletic trainer will have access to the health forms of students who elect to participate in athletics at Fitchburg State.

I have examined (Name): ____ Date:______________and found the following:

Height: _______________ Weight: _______________BP:_______________ Pulse: _____________ Respirations:_______________

Vision—Without glasses: Right 20/____Left 20/____ With glasses: Right 20/____Left 20/____ Color vision normal: ☐ yes ☐ no

Hearing—Right normal: ☐ yes ☐ no Left normal: ☐ yes ☐ no Hearing aid: ☐ yes ☐ no

Laboratory tests (optional): Glucose: _________________ HIV:________________ GM% Cholesterol: _______________ mg%

Medication allergies: ____

List Current Medications:____

Physical Exam (Subjective): ____

____

____

Abnormalities

No.	System	Yes	No
1.	Skin		
2.	Eyes		
3.	Ears		
4.	Nose, throat		
5.	Neck, thyroid		
6.	Lymphatics		
7.	Chest, breasts, lungs		
8.	Heart, rate/rhythm		
9.	Heart sounds		
10.	Abdomen, liver, kidneys, spleen		
11.	Hernia		
12.	Genitalia		
13.	Pelvic		
14.	Rectal		
15.	Extremities, back, spine		
16.	Neurological		
17.	Psychological		

List number and describe abnormality

I have known the applicant_________years. The applicant is in ☐ excellent ☐ good ☐ poor health.

The applicant ☐ does ☐ does not have a loss of or seriously impaired function of a paired organ.

The applicant ☐ should ☐ should not have additional ☐ medical ☐ psychological ☐ evaluation ☐ therapy.

The applicant may participate in sports ☐ without a restriction ☐ with the following restrictions ☐ should not participate in sports

Restrictions/Reason for limiting activity or sports:____

____

Plan ____

Signature:____ **Print name:**______________________________
Healthcare Practitioner Healthcare Practitioner

Healthcare Practitioner's Address:____

Healthcare Practitioner's Telephone:_________________________________ **Fax:**____________________________

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