Dean College Health Form

Student is REQUIRED to complete both sides of this form and return to:

Health Services
99 Main Street
Franklin MA 02038 USA
Tel: 508-541-1600 Fax: 508-541-1925
Email: healthservices@dean.edu

◈ **IMPORTANT** ◈

Please complete and return all required Health Forms before the deadline to avoid a registration hold & late fee.

Fall Semester - August 25
Spring Semester - January 15

◈ **LATE FEE** ◈

A $50 fee will be assessed if required health forms are not returned by the end of the 1st week of classes.

OFFICE USE:
Entered ________________
Hold cleared ☐ __________

STUDENT INFORMATION

Name____ **Date of Birth:** _____/_____/_____
Last First MI month day year

Home Address_______________________________________ **Soc. Sec. #** ______-______-______
Street

____ **Sex:** Female ☐ Male ☐
City or Town State Zip Country

Student Cell Phone # ______________________ **Student E-mail** __________________________

PARENT/GUARDIAN (for contact in case of emergency)

Name: ____ **Relationship:** ________________

Address: ____
Street City State Zip Country

Home Phone: (____)______________**Business Phone: (___)**______________ **Cell(____)**____________

TO ENSURE COMPLIANCE WITH MASSACHUSETTS INSURANCE REGULATIONS, ALL INTERNATIONAL STUDENTS ARE AUTOMATICALLY ENROLLED IN AND CHARGED FOR THE SCHOOL OFFERED HEALTH INSURANCE.

AUTHORIZATION and CONSENT for MEDICAL CARE

I (Student's Name) ___________________________________, consent to receive medical care @ Dean College Health Services or its Milford Regional Medical Center affiliates for treatment, which can include routine exams, emergency care, laboratory work, immunization administration or referrals when deemed necessary. I also understand and agree:

- To comply with all requests for medical information regarding vaccine status and entrance physical exam
- To the release of pertinent medical information to the designated Dean College Administrator in the case of an emergency or life-threatening event.

____ ___________________________
Student Signature (Parent/Guardian Signature, if student is under 18) **Date**

Student Name ____

Last First MI

MEDICAL HISTORY FORM

To be completed by Student

PERSONAL HISTORY: ***Check if you had or now have any of the following:***

- ☐ Acne
- ☐ Anemia
- ☐ Anorexia
- ☐ Anxiety
- ☐ Asthma
- ☐ Bee sting allergy
- ☐ Blind/visual impairment
- ☐ Bulimia
- ☐ Concussion
- ☐ Crohn's/colitis/IBS
- ☐ Deaf/hearing-impaired
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes–Type 1 or 2
- ☐ Eczema
- ☐ Frequent sore throats
- ☐ GERD
- ☐ Glasses/contacts
- ☐ Head injury
- ☐ Headaches
- ☐ Heart condition
- ☐ Heart murmur
- ☐ Hernia
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Insomnia
- ☐ Irregular periods
- ☐ Joint injury/repair
- ☐ Kidney disease/stones
- ☐ Learning disability
- ☐ Loss of paired organ
- ☐ Lyme disease
- ☐ Meningitis
- ☐ Mental health problem
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Narcolepsy
- ☐ Neuromuscular disease
- ☐ Phlebitis
- ☐ Pneumothorax
- ☐ Rheumatic fever
- ☐ Rheumatologic disorder
- ☐ Seasonal allergies
- ☐ Seizure disorder
- ☐ Sickle cell disease
- ☐ Skin problem
- ☐ STD
- ☐ Thyroid disease
- ☐ Tumor/cancer/ cyst
- ☐ Urinary tract infections
- ☐ Weakness/paralysis
- ☐ Weight gain
- ☐ Weight loss
- ☐ Whooping cough
- ☐ OTHER

____

____

____

Please include further information on above checked items or list other physical limitations, restrictions or additional limitations that may affect learning while at Dean College:

____

____

____

FAMILY HISTORY

	Present Age **or** Age at death	State of Health **or** Cause of death	Have any of your immediate relatives had any of the following:	No	Yes	Relationship
Father			Alcohol/Drug Problem			
Mother			Allergy, Asthma, hay fever			
Siblings			Cancer			
			Diabetes			
			Heart Disease			
			High Blood Pressure			
			Neurologic Disease			
			Mental Illness			

MEDICATIONS Please list all medications that you are presently taking:

______________________ ______________________

______________________ ______________________

______________________ ______________________

ALLERGIES Please list any allergies to medications, foods, insects, etc. and type of reaction:

______________________ ______________________

______________________ ______________________

HOSPITALIZATIONS If applicable, please list all medical, surgical and/or psychiatric hospitalizations, including date and diagnosis: ______________________ ______________________

______________________ ______________________

Primary Care Provider: ______________________ **Tel.**______________________

Physical Examination Form

To be completed by students doctor.
Return to Health Services before student arrives on campus to avoid registration hold and a late fee.

Dean College Health Services
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Franklin, MA 02038
Tel: 508 541-1600/Fax: 508-541-1925
Email: healthservices@dean.edu

Student Name____ **Date of Birth**_______________
Last First MI

PHYSICAL EXAM: Required of **ALL** new incoming students and yearly for athletes. **Any athlete without a current physical will be unable to participate in sports.** Your health care providers physical form signed and dated within the last year will be acceptable.

Please list any chronic illness or significant past medical history:
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Please list current medications and dosages:
_____________________________________ _____________________________________
_____________________________________ _____________________________________

Allergy to Medication, Food or Insect bites:____

Surgical Hx: ______________________________ _____________________________________

Height: ____________ **Weight**: _____________ **BP**________/_______ **Pulse**_______________

	NORMAL	ABNORMAL	Comment on abnormal
Skin			
H.E.E.N.T.			
Neck/Thyroid			
Lymph glands			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Neurologic			
Psychological			

Recommendations for Physical Activity: Unlimited: ________ Limited: ___________
If limited, please explain:

HEALTH CARE PROVIDER:
Signature ____**Date of Exam**________________

Name (or stamp) ____ Phone#_____________________

Address____Fax#________________

Certificate of Immunization

Dean College Health Services
99 Main Street
Franklin, MA 02038
Tel: 508 541-1600/Fax:508-541-1925
Email: healthservices@dean.edu

Student Name____ **Date of Birth**____________________
Last First MI

Massachusetts State Law requires the following immunizations of ALL students. Exact dates are required for immunizations or serological test results. Please include copies of laboratory reports, if titers done.

1. **Hepatitis B vaccine: #1____/____/____ #2____/____/____ #3____/____/____**
   Month/Day/Year Month/Day/Year Month/Day/Year

   OR positive titer:____/____/____ (anti-HBs/HBsAb) ***attach laboratory report***
   Month/Day/Year

2. **MMR** (measles, mumps, rubella) **2 doses required**
   #1: ____/____/____ (*on or after 1st birthday*) **#2:** ____/____/____ (*at least 1 month after 1st dose*)
   Month/Day/Year Month/Day/Year

   If no record of MMR vaccine, please indicate laboratory evidence of immunity:

   Measles (rubeola) positive titer: ____/____/____ **Result:** ______________
   Month/Day/Year ***attach laboratory report***
   Mumps positive titer: ____/____/____ **Result:** ______________
   Month/Day/Year ***attach laboratory report***
   Rubella positive titer: ____/____/____ **Result:** ______________
   Month/Day/Year ***attach laboratory report***

3. **Tdap** **(within last 10 years)** ____/____/____ **OR** **Td** **(within last 5 years)** ____/____/____
   Month/Day/Year Month/Day/Year

4. **Meningococcal Vaccine** (Groups A, C, Y and W-135)**:** ____/____/____ ☐ Menactra
   (within last 5 years) Month/Day/Year ☐ Menomune
   OR signed **DPH Waiver Form** ____/____/____
   Month/Day/Year

5. **Varicella Vaccine** **#1** ____/____/____ **#2**____/____/____
   Month/Day/Year Month/Day/Year

   History of chicken Pox Date: ____/____/____ **Positive Titer**: ____/____/____
   Month/Day/Year Month/Day/Year

6. **Tuberculosis Screening: Mantoux Skin Test** (PPD) **is required of all high-risk and international students, regardless of prior BCG inoculation. Please refer to TB Risk Questionnaire form and have student complete the 3 questions. If applicable, complete the following:**

Student is low risk for TB: ☐
PPD (within last 12 months): **Test date**: _____/_____/_____ **Result in mm:** ____________________
Chest X-ray date (in last 6 months, if positive PPD): ____/____/____ **Result**: _____________________
IF POSITIVE PPD, treatment with**:** ______________________ **Dates**: From_________ To_________

Health Care Provider: Office Phone and Fax#:__________________________/_________________________

____
Signature Date

Revised 06/14

TUBERCULOSIS RISK QUESTIONNAIRE

Dean College Health Services
99 Main Street
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Email: healthservices@dean.edu

Student Name____ **Date of Birth** _______________
Last First MI

	YES	NO
1. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?	☐	☐
2. Were you born in one of the countries listed below?	☐	☐
3. Have you traveled or lived for more than one month in one or more of the countries listed below?	☐	☐

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

* World Health Organization. Global tuberculosis control. WHO report 2002.

Afghanistan	Colombia	India	Moldova, Rep.	Senegal
Angola	Comoros	Indonesia	Mongolia	Sierra Leone
Armenia	Congo	Iran	Morocco	Solomon Islands
Azerbaijan	Congo, DR	Iraq	Mozambique	Somalia
Bahamas	Cote d'Ivoire	Kazakhstan	Myanmar	South Africa
Bahrain	Croatia	Kenya	Namibia	Sri Lanka
Bangladesh	Djibouti	Kiribati	Nepal	Sudan
Belarus	Dominican Rep.	Korea, DPR	New Caledonia	Suriname
Benin	Ecuador	Korea, Rep.	Nicaragua	Swaziland
Bhutan	El Salvador	Kyrgyzstan	Niger	Syrian Arab Rep.
Bolivia	Equatorial Guinea	Lao PDR	Nigeria	Tajikistan
Bosnia & Herzegovina	Eritrea	Latvia	Niue	Tanzania, UR
Botswana	Estonia	Lesotho	Northern Mariana Islands	Thailand
Brazil	Ethiopia	Liberia	Pakistan	Togo
Brunei Darussalam	Gabon	Lithuania	Palau	Tokelau
Burkina Faso	Gambia	Macedonia, TFYR	Panama	Turkmenistan
Burundi	Georgia	Madagascar	Papua New Guinea	Uganda
Cambodia	Ghana	Malawi	Paraguay	Ukraine
Cameroon	Guam	Malaysia	Peru	Uzbekistan
Cape Verde	Guatemala	Maldives	Philippines	Vanuatu
Central African Rep.	Guinea	Mali	Portugal	Vietnam
Chad	Guinea-Bissau	Marshall Islands	Romania	Yemen
China	Guyana	Mauritania	Russian Federation	Zambia
China, Hong Kong SAR	Haiti	Mauritius	Rwanda	Zimbabwe
China, Macao SAR	Honduras	Micronesia	Sao Tome & Principe	

- If you answered **YES** to <u>any</u> of the above questions, you are considered **“high-risk”** and are required to submit documentation of recent PPD testing on the **Certificate of Immunization** form. PPD testing should within the last 12 months.
- If you answered **NO** to all of the above questions, then you are considered **“low-risk”** and a tuberculin skin test is **NOT** required.

If the Mantoux PPD test is positive (≥10mm), you must submit a copy of a chest x-ray report in English dated within the last 6 months.

Please note: If you have had a positive tuberculin skin test in the past, you do not need another test. Please note prior treatment completed.