PLEASE NOTE

ALL Students are required to return the completed Health and Immunization Report to Health Services NO LATER THAN JUNE 30th for the Fall Semester and JANUARY 15th for Spring Semester.

Any student failing to provide this required documentation will be prohibited from registering for classes. A student's health record is strictly confidential and no information will be released without the student's written permission except as required by law or in a life-threatening emergency. This form must be completed in English

HEALTH REPORT

STONEHILL COLLEGE

Health Services
320 Washington Street
Easton, MA 02357-5710
TEL: 508-565-1307 FAX: 508.565.1510
www.stonehill.edu/health

FOR HEALTH SERVICES USE ONLY

Date Received:

All Requirements Complete ☐

Student to complete pages 1 and 2 before presenting form to health care provider. We suggest making a personal copy of this form before returning it.

Name: ______________________________ (Last / First / MI) ☐ Male ☐ Female Date of Birth: ____________ (Month / Day / Year)

Permanent Address: ______________________________ (Street) Stonehill ID# ____________

______________________________ (City / State / Zip / Country) Birthplace (Country): ____________

Home Telephone: ________ (Country Code if International) (______) (Area Code) ______________ Email: ____________

Date Entering Stonehill College: ______________ Cell Phone: (______) ____________

☐ Undergraduate Student ☐ Graduate Student ☐ Special Student ☐ Other ____________

If a transfer student, college(s) attended: ______________ Dates attended: ____________

EMERGENCY CONTACT:

1. Name: ______________
   Home Phone: ______(______) ______________
   Cell Phone:______(______)______________
   Relationship to Student: ______________

2. Name: ______________
   Home Phone: ______(______) ______________
   Cell Phone: ______ (______) ______________
   Relationship to Student: ______________

CONSENT FOR MEDICAL CARE

To be signed by students upon reaching their 18th birthday (if you are not yet 18 you must report to Health Services and sign this form when you turn 18).

I consent to **all** necessary medical care at Stonehill College or through a medical facility (when required).

Signature: ______________ Date: __________

To be signed by parent/guardian/or health care proxy agent; mandatory if student is under 18, optional (with student's permission) if over 18.

I give permission for the person named in this Health Report to receive **all** necessary medical care at Stonehill College or through a medical facility (when required).

Printed Name: ______________
Relationship: ______________

Signature: ______________ Date: __________

If a Health Care Proxy is available attach a copy to this form.

HEALTH INSURANCE INFORMATION

The State of Massachusetts mandates that all Stonehill College students taking three or more courses be enrolled in a qualifying health insurance plan. You may opt for the Stonehill College student health plan or provide your own private insurance. If you choose your own insurance, your plan **must** provide comparable coverage to the Stonehill College student health plan and that insurance **must** be billable in the State of Massachusetts.

Please call the number on the back of your insurance card to determine if you plan meets these conditions. Massachusetts Free Care is **NOT** a health insurance program as required by Massachusetts's law. Out of state Medicaid is **NOT** billable in the State of Massachusetts.

By Massachusetts State Law, if you do not meet these conditions, you can **NOT** attend college in the State of Massachusetts.

In July or January, you will receive detailed information regarding waiving or accepting the Stonehill College student health plan. Again, if you do not meet the conditions above, you must accept it.

All students need to carry a copy of their insurance card.

I have reviewed all of the information contained in this Health Form. It is true and accurate to the best of my knowledge.

Student Signature: ______________________________ Date:____/____/20____

Parent Signature: ______________________________ Date:____/____/20____ (required if student is under 18)

Student's Name: ____
Last First M.I.

MEDICAL HISTORY

You are **REQUIRED** to provide this information truthfully and accurately.

FAMILY HISTORY

Family Member	Age	State of Health	Age at Death	Cause of Death	Have any of your immediate relatives had any of the following:	Yes	Relationship
Father					Alcoholism	☐	
Mother					Asthma or Allergies	☐	
Siblings					Blood or Bleeding Disorder	☐	
					Cancer	☐	
					Diabetes	☐	
					Heart Disease	☐	
Spouse					High Blood Pressure	☐	
Children					Kidney Disease	☐	
					Mental Illness	☐	
					Seizure Disorder	☐	
					Tuberculosis	☐	

PERSONAL HISTORY

1. ☐ Acne
2. ☐ Anemia
3. ☐ Anorexia Nervosa/Bulimia
4. ☐ Appendectomy
5. ☐ Arthritis
6. ☐ Asthma
7. ☐ Blind/visual impairment
8. ☐ Cancer/malignancy
9. ☐ Chickenpox
10. ☐ Crohn's/Colitis/IBS
11. ☐ Deaf/hearing impairment
12. ☐ Depression
13. ☐ Diabetes
14. ☐ Emotional/mental illness
15. ☐ Heart Disease/Problem
16. ☐ Hepatitis (Type________)
17. ☐ High Blood Pressure
18. ☐ High Cholesterol
19. ☐ HIV Infection/disease
20. ☐ Impaired Mobility/Paralysis
21. ☐ Kidney Stone
22. ☐ Kidney Disease
23. ☐ Learning Disability:_______
24. ☐ Malaria
25. ☐ Migraines
26. ☐ Mononucleosis
27. ☐ Neuromuscular disease
28. ☐ Phlebitis/deep vein clot
29. ☐ Pneumothorax
30. ☐ Positive TB test
31. ☐ Seizure Disorder
32. ☐ Sickle Cell Disease
33. ☐ Thyroid Disease
34. ☐ TB/Tuberculosis
35. ☐ Ulcer/stomach problem
36. ☐ UTIs (frequent)
37. ☐ Other_____________

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates): ____

____

GYNECOLOGICAL HISTORY (check all that apply) Age at onset of menses: ________________

Date of last PAP Smear: _____/_____/_____ Result: _______ Have you ever had an abnormal pap smear? _____ Colposcopy?_____ Date: _____/_____/_______

☐ Irregular periods/no periods ☐ Painful Cramps ☐ DES Exposure ☐ Breast Lumps/Fibrocystic Disease

MAJOR ILLNESS, OPERATIONS, OR HOSPITALIZATIONS: If any, provide details including dates, diagnoses, surgeries, etc. ____________________________

____

MEDICATIONS: Please list all (prescription and OTC) ____

____

ALLERGIES: Please specify, including **medications**, insect venom, foods, etc. ____

____

☐ Yes ☐ No Do you smoke? How many cigarettes a day? _____ For how many years? _____
☐ Yes ☐ No Do you drink alcohol? How often? _____ How many drinks do you have on the average in one evening? _____
☐ Yes ☐ No Do you exercise? What type? ______________________________ How often? ______________________________
☐ Yes ☐ No Do you wear a helmet when biking/roller blading?
☐ Yes ☐ No Do you examine your breasts/testicles regularly?
☐ Yes ☐ No Do you follow any special diet? What kind? ______________________________
☐ Yes ☐ No Are you concerned about your eating patterns?
☐ Yes ☐ No Are you concerned about your weight? Do you consider yourself: ☐ underweight ☐ overweight ☐ normal weight
☐ Yes ☐ No Do you often have a feeling of being overwhelmed or depressed?
☐ Yes ☐ No Have you ever received treatment or counseling for an emotional problem? Dates of treatment: ____________________
☐ Yes ☐ No Are you concerned about your own, a friend's or family member's drinking or drug use?
__________% When you travel in a car, what percentage of the time do you wear a seat belt?

Is there anything else the College should know about your medical history? ____

____

____

____

____

IMMUNIZATION RECORD

HEALTH CARE PROVIDER TO COMPLETE pages 3 and 4. Please review the student's history on page 2, complete and sign the Immunization Record (Page 3) and complete and sign the Medical Report/Clinician's Recommendations (Page 4). Thank you for your time.

Stonehill College complies with Massachusetts College Immunization Law, Chapter 76, and related regulations of the Massachusetts Department of Public Health. This means that the following section related to **required** immunization must be completed in its entirety or student will be refused registration. Exact dates are required and/or copies of serological immunity **may be attached.** History of disease for any **required** immunization is not acceptable documentation**.** Medical and Religious **EXCEPTIONS** to required immunizations are granted only if in compliance with Massachusetts State Law. Philosophical exemptions are not allowed even if signed by a physician. Documentation must be attached.

Student's Name: ______________________________________ Date of Birth: ____/ ____/ _____
Last First M.I.

REQUIRED IMMUNIZATIONS If serology titer was done, please attach copy of laboratory report.

			Month	**Day**	**Year**
A.	**MMR (MEASLES, MUMPS, RUBELLA) 2 doses required**				
	☐ Dose 1 Immunized on or after first birthday	Dose 1	______	______	______
	☐ Dose 2 Given at least one month after Dose 1	Dose 2	______	______	______
	OR Laboratory test proving immunity (attach lab reports)				
	Measles: ☐ Immune – Titer value ______	Date:	______	______	______
	Mumps: ☐ Immune – Titer value ______	Date:	______	______	______
	Rubella: ☐ Immune – Titer value ______	Date:	______	______	______
B.	**TETANUS-DIPHTHERIA** Immunization booster **within the last 10 years**				
	PLEASE NOTE: A one-time dose of Tdap is recommended, if at least 2-5 years since last Td				
	Td ☐ OR Tdap ☐	Date:	______	______	______
C.	**HEPATITIS B VACCINE 3 doses required**	Dose 1	______	______	______
		Dose 2	______	______	______
	OR Laboratory test proving immunity (attach lab reports)	Dose 3	______	______	______
	Positive Hepatitis B surface antibody ☐ Reactive ☐ Non-reactive	Date:	______	______	______
D.	**MENINGOCOCCAL MENINGITIS** Vaccine ☐ **Menomune** (MPSV4) ☐ **Menactra** (MCV4)	Date:	______	______	______
	OR signed Massachusetts Meningitis Immunization Waiver Form ☐ **Only enclosed form acceptable**				
	Required for full-time residential students				

RECOMMENDED IMMUNIZATIONS/SCREENINGS

A.	**VARICELLA** History of disease – Date:_______________				
	OR Positive Varicella antibody titer ☐ (attach copy of lab report)	Date:	______	______	______
	OR Varicella vaccine ☐	Dose 1	______	______	______
		Dose 2	______	______	______
C.	**HEPATITIS A**	Dose 1	______	______	______
		Dose 2	______	______	______
D.	**HUMAN PAPILLOMAVIRUS** (HPV) Currently for females only: *Gardasil Vaccine*	Dose 1	______	______	______
		Dose 2	______	______	______
		Dose 3	______	______	______

E. **TUBERCULOSIS SCREENING** (recommended within past 6 months regardless of prior BCG inoculation)

☐ This student has been screened for his/her risk to tuberculosis and it has been determined he/she is not at risk requiring testing.

☐ **PPD** (Mantoux) test result: ☐ Negative ☐ Positive Induration _____ mm. Date: ______ ______ ______

☐ **CHEST X-RAY** (in the past 6 months if positive PPD) Result: ☐ Negative ☐ Positive Date: ______ ______ ______

☐ If positive PPD, treatment with: ___________________ Dates of treatment: From: _____ To: _____

HEALTH CARE PROVIDER

Name: ____________________________________ Signature: ____________________________________

FOR HEALTH SERVICES USE ONLY

Vaccine	Date Given	Dose	Site	Manufacturer	Exp. Date/Lot #	Date on VIS	Admin. By	Student Signature

MEDICAL REPORT/CLINICIAN'S RECOMMENDATIONS

Student's Name: ____ Date of Birth: ____/ ____/ _____
Last First M.I.

Height: _______________ Weight: _______________ BP: _______________ Pulse: _______________

CURRENT AND CHRONIC PROBLEMS

1. ______________________ 4. ______________________
2. ______________________ 5. ______________________
3. ______________________ 6. ______________________

ALLERGIES

ALL CURRENT MEDICATIONS

PHYSICAL LIMITATIONS OR RESTRICTIONS

DIETARY REQUIREMENTS

PHYSICAL EXAMINATION

A physical examination is ***strongly recommended***, but is not required. If a physical examination is conducted please attach documentation.

ADDITIONAL COMMENTS

HEALTH CARE PROVIDER

Today's Date: _____/_____/20_____

Name: ______________________ Signature: ______________________

Title: ______________________ Address: ______________________

Telephone: (_______) ______________________ Fax: (_______) ______________________

Email: ______________________ Web Site: ______________________

Mail completed form to: Stonehill College Health Services, 320 Washington Street, Easton, MA 02357-5710