Medical Form

Westfield State University: Westfield CSI Program
MAKE YOUR DOCTOR APPOINTMENT EARLY!
Per Board of Health
Pages 1 & 2 to be completed by Parent/Guardian, 3 by physician

MUST BE RETURNED NO LATER THAN June 5, 2020.

Name:_____ Age:_____ Birth Date:____/____/_____ Gender:_____

Operations/serious injuries (Describe and give dates): _____

_____

_____

Chronic or recurring illnesses:_____

Check any that apply:
_____Frequent Ear Infections
_____Heart Defect
_____Convulsions
_____Diabetes
_____Bleeding (Clotting)

Allergies
_____Hay Fever
_____Poison Ivy
_____Insect Sting
_____Penicillin
_____Other Drug Allergy

Diseases
_____Chicken Pox
_____Measles
_____Measles/German
_____Mumps
_____Asthma
_____Other

Please describe care as necessary to handle asthma:

_____

Please describe care as necessary to handle diabetes:

_____

OTHER ALLERGIES (Insects, Food, Plants, Animals, Medicines, Other):

_____

_____

If Epi-Pen is required to handle allergic reaction, family must supply one.

Is Student on a special diet? Please explain what they cannot eat:

_____

_____

Statement of emotional and mental health from parents *(Required)*
(Please share with us any information about your child's emotional or mental health that might aid us in caring for him or her while enrolled in the program):

_____

_____

IMMUNIZATION HISTORY

Vaccines:

Hepatitis B:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Dipitheria:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Tetanus:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Injectable Polio (Salk):_____ Date:_____ Basic Immunization:_____Last Booster:_____

Measles:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Rubella:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Tuberculin:_____ Date:_____ Basic Immunization:_____Last Booster:_____

Hepatitis B:_____ Date:_____ Basic Immunization:_____Last Booster:_____

_____ All immunizations part of 105 CMR 430.152 have been fulfilled.

Name of Dentist or Orthodontist:_____Tel:_(_____)_____

Name of Family Physician:_____Tel:_(_____)_____

Student medical insurance carrier:_____ Policy #:_____

Name on Insurance Card:_____

Parent authorization: This health history is accurate as far as I know and the person herein described has permission from me to engage in all prescribed activities, except as noted by myself or the examining physician. I hereby give the physician selected by the program director to order x-rays, routine tests and treatment for the health of my child in the event I cannot be reached in an emergency. I also hereby give my permission to the physician selected by the program to hospitalize, secure proper treatment for, order injection, and/or surgery for my child as named above.

Parent/Guardian Signature: _____

Parent/Guardian Name (Please Print):_____

Date: _____/_____/_____

Student's name: _____

Date examined: _____

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OFFICE USE ONLY

Date Sent:_____/_____/_____
Date Received:_____/_____/_____

Medical Examination (To be completed by licensed physician)
This examination should be performed within one calendar year of arrival.
Examination for some other purpose within this period is acceptable.
Please also have physician review first two pages of Medical Form

Name:_____ Age:_____ Birth Date:____/____/_____ Gender:_____

Examination is for the purpose of determining fitness to engage in any strenuous physical activities.

Code : **V** = Satisfactory **X** = Not Satisfactory **O** = Not Examined

Height:_____	Contacts:_____	Lungs:_____
Weight:_____	Ears:_____	Abdomen:_____
B.P.:_____	Nose:_____	Hernia:_____
Hct. or Hgb:_____	Throat:_____	Extremities:_____
Urinalysis:_____	Heart:_____	Posture:_____
Eyes:_____	Genitalia:_____	Skin:_____
Glasses:_____		

Height:_____ Weight:_____

Recommendations and special considerations while in program:

Special Diet:_____

Strenuous Activity:_____

Other:_____

Current Medications:_____

Other:_____

_____

_____

_____

I have examined the person herein described and have reviewed the health history as well as the other information in this three-page form . It is my opinion that this student is physically able to engage in program activities except as noted above. Please attach additional comments or information if needed.

Signed: _____M.D.
Examining Physician

Please Print Name:_____

Telephone: (_____)_____

Address:_____

Date:_____/_____/_____