



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 4, 2019.

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: _____

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: ____/____/____