**Note to the Student:**
Unless **ALL** required **immunizations** and **physical examination** are submitted you will be **administratively withdrawn** and a fee will be assessed for reinstatement.

# WESTFIELD STATE COLLEGE
# STUDENT HEALTH FORM

SIDE 1 - TO BE FILLED OUT BY THE STUDENT

**IMPORTANT**
**Return this form to:**
**WSC Health Services**
**P.O. Box 1630**
**Westfield, MA**
**01086-1630**
**Fax: 413-572-5545**

## REPORT OF MEDICAL HISTORY

Please complete before going for your physical examination.

Please Print:

Name: Last First M.I. Student ID# Date of Birth

Home Address: Street City State Zip Phone Cell Phone

Next of Kin: Name/Relationship Home Phone Business Phone Cell Phone

Next of Kin: Name/Relationship Home Phone Business Phone Cell Phone

Health Insurance Carrier (if possible send copy of card) Policy Number Card Holder

**Emergency**: Permission is hereby granted for the emergency use of anesthesia and emergency medical treatment for my minor. Every effort will be made to contact the parents.

Signature: ____________________________________________
Parent or Legal Guardian

**MEDICAL HISTORY:**

**Drug Allergies: Yes____ No____** If YES, list drug and reaction:____________________

Other Allergies: seasonal, insects, foods etc:____________________

Please check yes or no on each line.

| History of: | Yes | No | History of: | Yes | No | History of: | Yes | No |
|---|---|---|---|---|---|---|---|---|
| Anemia | | | Gastro Intestinal Problems | | | Strep Throat | | |
| Asthma | | | Head Injury | | | Substance abuse/Alcoholism | | |
| Back Injury/Problem | | | Headaches (Recurrent) | | | Surgery | | |
| Blood Transfusion | | | Hearing Deficit | | | Appendectomy | | |
| **Chickenpox: Date** (if known)**:** | | | Heart Murmur | | | Tonsillectomy | | |
| Contact Lenses | | | Hepatitis | | | Other surgery-comment below | | |
| Depression/Anxiety | | | High Blood Pressure | | | Tobacco user | | |
| Diabetes | | | Kidney Problem | | | Tuberculosis | | |
| Disease/Injury of joints/bones | | | Learning Disability | | | Thyroid Disease | | |
| Ear, Nose, Throat Problems | | | Mononucleosis | | | Urinary Tract Infection | | |
| Eating Disorders | | | Seizures | | | FEMALES ONLY: | | |
| Eye Problems | | | Sickle Cell Trait | | | Birth Control | | |
| Fainting | | | Skin Condition: | | | Menstrual Disorder | | |

Comments on medical/psychiatric history:

____________________________________________

List any daily medications/condition for which medications are prescribed:

____________________________________________

Special needs student: Nature of Disability/Special medical nursing needs:

____________________________________________

____________________________________________ Will you live on campus? Please circle- Yes No
Student's Signature Date

**TO THE STUDENT: This information is confidential & will not be released without your knowledge and written consent. The College will not be liable for any medical history information that is omitted from this form.**

**SIDE 2 - TO BE FILLED OUT BY THE PHYSICIAN**

Name:_________________________ DOB:__________ Male ( ) Female ( )

*Please complete required **Immunizations (Month & Year) & Physical Exam sections before mailing.**

****Required for full time undergraduate, residential students or signed meningitis information waiver form must be submitted.**

| VACCINATIONS ✷ = *Required* | DATE Mo/Yr | DATE Mo/Yr | DATE Mo/Yr | DATE Mo/Yr | LABS Urinalysis |
|---|---|---|---|---|---|
| ***Tdap** (booster within 10 years) | #1 | | | | Glucose: |
| ***MMR (2 doses required or titers)** | #1. | #2. | | | Micro: |
| or *MMR titers Please circle results and note date | 1. Measles (Rubeola) Pos Neg Date: | 2. Mumps Pos Neg Date: | 3. Rubella Pos Neg Date: | | **Blood** Hgb. Hct. |
| ***Hepatitis B series 20mcg** | #1. | #2. | #3. | | |
| or ***Hepatitis B 2 dose series 10mcg** | #1. | #2. | or | Immune Titer Date: | |
| ****Menactra/Menveo** or **Menomune** Get booster if Menomune date within 5yrs | **Menactra / Menveo** | **Menomune** | | | |
| ***Varicella/VAR if no history of chickenpox 2 vaccinations required** | #1. | #2. | **History of Chickenpox Date:** | **or Titer:** Pos Neg | |
| **HPV Vaccine** | #1. | #2. | #3 | | |
| PPD Mantoux TB Test: (see separate form) **Follow MA State guidelines for risk**: | Month/Year | Neg mm | Pos mm | **If positive, chest x-ray report is required** | |

- **PHYSICAL EXAMINATION:** Please review the information on Side 1 and complete this side.

HT: __________ WT:__________ BP: __________ Pulse: __________

SYSTEMS REVIEW: Are there any abnormalities of the following?

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| 1. Ears, Nose or Throat | | | 7. Genitourinary | | |
| 2. Eyes | | | 8. Musculoskeletal | | |
| 3. Respiratory | | | 9. Neuropsychiatric | | |
| 4. Cardiovascular | | | 10. Metabolic/endocrine | | |
| 5. Gastrointestinal | | | 11. Lymph | | |
| 6. Hernia | | | 12. Skin | | |

Comments: ____________________________________________

Is the student now under treatment for any medical or emotional condition? Yes ( ) No ( )

Explain: ____________________________________________

**Drug Allergies: Yes**_____ **No**_____ If YES, list drug and reaction: ______________________

Present Medications: ____________________________________________

Recommendations for physical activity: Unlimited ( ) Limited ( ) Sickle Cell Trait: Yes ( ) No ( )
Is the student fit to participate in intercollegiate athletic competition? Yes ( ) No ( )
Define activities to be restricted, if applicable: ______________________

**Physician's Signature**: ______________________ Address: ______________________

**Date**: ______________________ City: ______________________

Printed Name: ______________________ State: __________ Zip: __________

License # & State: ______________________ Phone: ______________________

**MAIL FORMS TO ADDRESS ON FRONT SIDE** **Questions: Phone 413-572-5415** **Fax: 413-572-5545**