

STUDENT HEALTH CENTER

Student wellness is taken seriously at Fisher College. Our Health Center provides a number of services to our students, including an on-staff nurse, a medical doctor, counseling services and out-patient referrals. The Health Center is also responsible for maintaining health and immunization records for all students.

THE HEALTH CENTER HAS REGULAR CLINIC HOURS.

Please feel free to contact us for medical assistance as well as any questions about medical issues. The enclosed medical forms are required for registration.

In order to welcome you to campus, we need to have all completed paperwork on hand for you.

STATE LAW STATES THAT ALL HEALTH PAPERWORK IS DUE TO THE HEALTH OFFICE BY AUGUST 1, 2011.

If you have not turned in all of your health paperwork by then, you will be assessed a \$100.00 administrative processing fee to handle your late paperwork. Additionally, any missing parts of your health paperwork may result in additional health fees for immunizations, etc. Finally, failure to submit fully complete health paperwork by October 1, 2011 may result in dismissal from Fisher College. Please complete your health paperwork as soon as possible. Below is a checklist to assist you in making sure that all forms are complete and sent in to our office. **Please complete everything listed below.**

To be completed by the student

Health Records

- Permanent address and contact information
- Address and contact information while in school
- Emergency Contacts

Medical History

- Family history (include all that apply)
- Individual history (check all that apply)
- Hospitalizations
- Allergies (food, drug, etc)
- Lifestyle questions

Health Insurance (required by law)

- Enroll if no other comparable insurance plan is available
- Submit Waiver request if personal insurance plan meets state requirements

To be completed by physician/medical professional

Immunizations

- Measles/Mumps/Rubella (required by state law)
- Tetanus/Diphtheria (required by state law)
- Tuberculosis (strongly recommended for public health reasons)
- Hepatitis B (required by state law)
- Chicken pox history/vaccination (status recommended for public health reasons)
- Meningitis (required by state law for all residential students)
- Hepatitis A
- Polio

Physical Examination

- Occurred within past year
- Note any areas of concern, chronic treatment

All of these items must be completely filled out and returned to us by **AUGUST 1, 2011** to insure that you can easily begin classes on campus and to avoid the \$100.00 administrative fee.

Thank you in advance for your cooperation. Please feel free to contact the Health Center at **617-236-8860**.



FISHER COLLEGE

Fisher College Health Center
118 Beacon Street, Boston, MA 02116
Phone: 617.236.8860 Fax: 617.236.5465

Health Record

STUDENT COMPLETES THIS FORM

PLEASE NOTE: ALL STUDENTS are required to return the completed HEALTH and IMMUNIZATION REPORT by August 1, 2011. Students who are admitted after this date must bring their forms to check-in day. Any student failing to provide this required documentation will be prohibited from registering and attending classes.

INSTRUCTIONS: This form must be completed in ENGLISH. Please complete all forms labeled ***Student Completes This Form.*** Please have the student's physician complete and return all forms labeled ***Physician Completes This Form.***

Name: _____ Male Female Date of Birth: _____
Last First MI Month Day Year

Permanent Address: _____
Street City State Zip

Soc. Sec. #: _____ Birthplace (Country): _____

Home Telephone: (_____) (_____) _____ Cell Phone: (_____) _____
Country Code if International Area Code Area Code

Local Address: _____
Street City State Zip

Local Phone: (_____) _____

Father/Guardian's Name: _____ Mother/Guardian's Name: _____

Father/Guardian's Home Phone: (_____) _____ Mother/Guardian's Phone: (_____) _____

Father/Guardian's Profession: _____ Mother/Guardian's Profession: _____

Father/Guardian's Business Phone: (_____) _____ Mother/Guardian's Business Phone: (_____) _____

Date entering Fisher College: _____ Status: Undergraduate Cont. Ed. ELI Transfer

College(s) attended: _____ Dates attended: _____

Alternate Emergency Contact

Name: _____
Last First Relationship

Address: _____
Street City State Zip

Home Telephone: (_____) _____ Business Telephone: (_____) _____

CONSENT FOR EMERGENCY TREATMENT

To be signed by parent/guardian if student is under 18 years of age:

I give permission for medical treatment for my son/daughter

In the event of an accident or illness, this includes referral to a local hospital, hospitalization, anesthesia and/or surgery should it be necessary and I am unable to be reached.

Signature _____ Date _____

CONSENT FOR EMERGENCY TREATMENT

To be signed by student over 18 years of age:

I consent to care at the College Health Center.

Signature _____ Date _____

FOR HEALTH SERVICES USE ONLY

Date Received: _____

Allergies: _____

Complete: Rubella: CXR

Exemption: Tetanus: INH

Measles: #1 #2 Hepatitis B: Physical Exam

Mumps: PPD Labs

Please return to Health Center @ 118 Beacon Street, Boston, MA 02116



FAMILY HISTORY

Please list all family members	Age	State of health	Age at death	Cause of death	Have any of your immediate relatives had any of the following:		
					Illness	<input checked="" type="checkbox"/> for yes	Specify which relative
Father					Alcoholism		
Mother					Asthma or Allergies		
Brothers					Blood or Bleeding Disorder		
					Cancer		
Sisters					Diabetes		
					Heart Disease		
Spouse					High Blood Pressure		
Children					Kidney Disease		
					Mental Illness (please specify)		
					Seizure Disorder		
					Tuberculosis		

STUDENT'S HISTORY

Do you have now or have you ever had: (check all that apply)

- | | | | |
|--|--|---|--|
| 1. <input type="checkbox"/> Abnormal Pap | 13. <input type="checkbox"/> Depression | 24. <input type="checkbox"/> Individualized Education Plan | 34. <input type="checkbox"/> Phlebitis/deep vein clot |
| 2. <input type="checkbox"/> Anemia/Bleeding Disorder | 14. <input type="checkbox"/> Frequent ear problems | 25. <input type="checkbox"/> Irregular Heartbeat | 35. <input type="checkbox"/> Pneumothorax |
| 3. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 15. <input type="checkbox"/> Eye problem | 26. <input type="checkbox"/> Irritable Bowel Syndrome | 36. <input type="checkbox"/> Positive TB test |
| 4. <input type="checkbox"/> Appendectomy | 16. <input type="checkbox"/> Fainting | 27. <input type="checkbox"/> Kidney stone | 37. <input type="checkbox"/> Rheumatic fever |
| 5. <input type="checkbox"/> Arthritis | 17. <input type="checkbox"/> Severe head injury | 28. <input type="checkbox"/> Kidney disease/Urinary Infection | 38. <input type="checkbox"/> Seizure disorder |
| 6. <input type="checkbox"/> Anxiety | 18. <input type="checkbox"/> Heart disease/problem | 29. <input type="checkbox"/> Learning disability | 39. <input type="checkbox"/> Sickle cell disease/trait |
| 7. <input type="checkbox"/> Asthma | 19. <input type="checkbox"/> Heart murmur/click | 30. <input type="checkbox"/> Malaria | 40. <input type="checkbox"/> Testicular problem |
| 8. <input type="checkbox"/> Bone or Joint Problem | 20. <input type="checkbox"/> Hepatitis/Jaundice | 31. <input type="checkbox"/> Recurrent Headache | 41. <input type="checkbox"/> Thyroid disease |
| 9. <input type="checkbox"/> Cancer/malignancy | 21. <input type="checkbox"/> High blood pressure | 32. <input type="checkbox"/> Mononucleosis | 42. <input type="checkbox"/> Tuberculosis |
| 10. <input type="checkbox"/> Chickenpox | 22. <input type="checkbox"/> HIV infection | 33. <input type="checkbox"/> Neuro-muscular disease | 43. <input type="checkbox"/> Ulcer |
| 11. <input type="checkbox"/> Colitis/Ileitis | 23. <input type="checkbox"/> Impaired mobility/paralysis | | 44. <input type="checkbox"/> Other serious illness or injury, mental illness |
| 12. <input type="checkbox"/> Diabetes | | | |

Do you smoke? No Yes
How many cigarettes a day? ___ For how many years? ___

Do you drink alcohol? No Yes How often? _____
If you drink, how many drinks do you have on the average in one evening? ___

Do you exercise? No Yes What type? _____
How often? _____

When you travel in a car, what percentage of the time do you wear a seatbelt? ___%

Do you wear a helmet when biking/roller blading? No Yes

Do you examine your breasts/testicles regularly? No Yes

Do you follow any special diet? No Yes
What kind? _____

Are you concerned about your eating patterns? No Yes Or your weight? No Yes

Do you consider yourself:
 underweight overweight normal weight

Do you often have a feeling of being overwhelmed or depressed? No Yes

Have you ever received treatment or counseling for an emotional problem? No Yes

Are you concerned about your own, a friend's or family member's drinking or drug use? No Yes

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS:

(If any, provide details including dates, diagnoses, surgeries, etc.)

ALLERGIES:

(Please specify, including medications, insect venom, food, etc.)

GYNECOLOGICAL HISTORY

(female students only – check all that apply)

Age at onset of menstrual cycle _____ Length of cycle _____

Date last PAP smear _____ Result: _____

Have you ever had: colposcopy? (Date) _____

Irregular periods/no periods Painful cramps

DES exposure Breast lumps/Fibrocystic Disease

Explain all positive answers (please include dates):



In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15, Fisher College requires verification of immunity for measles, mumps, rubella, tetanus and diphtheria; the Hepatitis B series is required by law as of September 2001. As of 2005, all incoming residential freshmen are required to have the meningococcal vaccine.

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

I. REQUIRED IMMUNIZATION

MMR (MEASLES, MUMPS, RUBELLA)

(If immune by titer, a copy of the lab report, with the value in ENGLISH, is required.) Month Day Year
 If given instead of individual immunizations, **2 doses required.**

Dose 1 – Immunized on or after first birthday.....Dose 1 ___ / ___ / ___
 Dose 2 – Given at least one month after Dose 1Dose 2 ___ / ___ / ___

MEASLES (RUBEOLA) If given instead of MMR, **2 doses required.**

Dose 1 – Immunized with live measles vaccine on or after first birthday.....Dose 1 ___ / ___ / ___
 Dose 2 – Given at least one month after Dose 1Dose 2 ___ / ___ / ___

If unable to document 2 Measles Immunization dates, must provide:

Measles serology immune titer value _____ Interpretation: Immune Not ImmuneDate: ___ / ___ / ___

MUMPS If given instead of MMR, **1 dose required.**

Immunized with vaccine on or after first birthdayDate: ___ / ___ / ___

If unable to document Mumps Immunization date, must provide:

Mumps serology immune titer value _____ Interpretation: Immune Not ImmuneDate: ___ / ___ / ___

RUBELLA If given instead of MMR, **1 dose required.**

Immunized with vaccine on or after first birthdayDate: ___ / ___ / ___

If unable to document Rubella Immunization date, must provide:

Rubella serology immune titer value _____ Interpretation: Immune Not ImmuneDate: ___ / ___ / ___

TETANUS-DIPHTHERIA

Completed primary series of tetanus-diphtheria immunizationsDate: ___ / ___ / ___

Received tetanus-diphtheria booster **within last 10 years**.....Date: ___ / ___ / ___

Indicate type of last booster shot (check one) Td Tdap

TUBERCULOSIS SCREENING

Date and test results required. BCG Vaccine is not a contra-indication to testing.

PPD (Mantoux) test within the past 6 months. Negative Positive Induration ___ mmDate: ___ / ___ / ___

Chest x-ray (in the past 6 months if positive PPD) Result: Negative PositiveDate: ___ / ___ / ___

Chest x-ray reports must be in ENGLISH.

If positive PPD, treatment with _____Date: ___ / ___ / ___

HEPATITIS B VACCINE

(If immune by titer, a copy of the lab report, with the value in ENGLISH, is required.)

Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___ Dose 3 ___ / ___ / ___
Month Day Year Month Day Year Month Day Year

MENINGOCOCCAL VACCINE

Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___
Month Day Year Month Day Year

VARICELLA VACCINE

Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___ Indicate date of clinical history ___ / ___ / ___
Month Day Year Month Day Year Month Day Year

II. NON-REQUIRED IMMUNIZATIONS

Hepatitis A Vaccine Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___
Month Day Year Month Day Year

Polio Vaccine Dose 1 ___ / ___ / ___ Dose 2 ___ / ___ / ___ Dose 3 ___ / ___ / ___ Dose 4 ___ / ___ / ___
Month Day Year Month Day Year Month Day Year Month Day Year

MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER (Please print)

Name _____ MD, NP, PA, DO Telephone (_____) _____

Address _____ Signature _____

Please return to Health Center @ 118 Beacon Street, Boston, MA 02116



PHYSICIAN COMPLETES THIS FORM

Physical Examination

(MUST BE COMPLETED WITHIN THE PAST YEAR)

Student's Name: _____ Date of Exam: _____

Height _____ Weight _____ BP _____ Pulse _____

Hearing: Right _____ Left _____

Vision: Without correction: Rt. 20/____ Left 20/____ With correction: Rt. 20/____ Left 20/____

Color vision normal: Yes No

The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.

SYSTEM	✓ if NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary/Reproductive		
Pelvic		
Lymphatic		
Musculo-skeletal		
Neurological		
Endocrine		
Psychological		
Teeth/Mouth		
Lab work: Hgb/Hct _____ Cholesterol _____ Urine: Glucose: _____ Protein _____ Micro _____		

CURRENT MAJOR AND CHRONIC PROBLEMS:

ACUTE OR MINOR PROBLEMS:

If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.

Additional comments and recommendations: _____

Please list all **MEDICATIONS** currently being taken (include Vitamins, Over-the-Counter Medication, Contraceptives, Inhalers, Epi-Pens, Allergy Injections): _____

Recommendations for physical activity: unlimited limited (specify) _____

MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER (please print)

Health Care Provider _____ MD, NP, PA, DO

Address _____

Phone (_____) _____ Fax (_____) _____

Provider's Signature: _____

