SPRINGFIELD COLLEGE HEALTH CENTER
263 Alden St., Springfield, MA 01109
(413) 748-3175 / (413) 748-3444 (fax)
healthcenter@springfield.edu

Please do not submit partially completed forms.

Health requirements are only considered fulfilled when all three pages have been successfully completed.

HEALTH FORM

Forms are due no later than Dec. 15 for spring entry, April 15 for summer entry, and July 15 for fall entry.
PLEASE NOTE: Full clearance for registration *will not* be granted until all health requirements are met.
I will be: __ First Year Undergrad __ First Year Grad __ Transfer __ NCAA Athlete (Sport: _____)

Name (last, first, middle):	
Identified Gender: ☐ Male ☐ Female ☐ Transgender ☐ Other	
Preferred Name:	**Pronouns:**
Date of Birth:	**Email:**
Address:	**City/State/Zip Code:**
Telephone Numbers: Home:	Cell:
Emergency Contact: Name:	Relationship: Phone:

MEDICATIONS / ALLERGIES

CURRENT MEDICATIONS: Name of Medication/Dosage		NONE: ____
Medication Allergies:	Other Allergies:	NONE: ____

PERSONAL HISTORY

Have you ever had:	YES	NO		YES	NO		YES	NO
ADD/ADHD			Eye/Vision Disorder			Joint/Bone Disease		
Anxiety/Depression			Eating Disorder			Kidney Disease		
Asthma			Headaches/Migraines			Mononucleosis		
Bleeding Disorder			Head Injury/Concussions			Seizures		
Cancer			Heart Disease/Murmur			Sickle Cell Trait		
Diabetes			High Blood Pressure			Tobacco Use		
Dizziness/Fainting			High Cholesterol			Other		
Ear/Hearing Disorder			Hospitalizations/Surgeries					

Include date and year, description, and complications for each "yes" response (use separate page if needed).

FAMILY HEALTH STATUS

	Age	State of Health	Significant Illnesses
Father			
Mother			
Sibling(s)			

You MUST answer the following Tuberculosis risk questions:
Have you ever had close contact with anyone sick with TB? __ Yes __ No
Were you born or lived for more than 1 month outside of the United States? __ Yes __ No
If you answered YES to either of the TB questions above *please print out the TB form and bring to your physical appointment* as you may need a TB skin test.

CONSENT FOR TREATMENT: In case of serious illness or accident, I give Springfield College Health Center medical staff, or its representative(s), permission to secure medical and/or surgical care deemed necessary for my health. I authorize the Health Center medical staff to perform medical care and immunizations as deemed necessary by licensed personnel. Also, I have read the Notice of Privacy Practices, which pertains to the Health Insurance Portability and Accountability Act (HIPAA), disclosing how Springfield College may use and disclose my protected health information.

STUDENT SIGNATURE (parent if student is under 18 on day 1 of classes) **DATE**

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PHYSICAL EXAMINATION

(MUST BE COMPLETED BY A LICENSED MD, DO, NP or PA)

In lieu of a provider completing this form you may attach documentation of a physical exam but it must include Provider Recommendations/clearance for activities*

Admission requirement: Physical Exam within 2 years of start date

NCAA Athletes: Please note that the NCAA requires physical examination within six months of matriculation to Springfield College for sports clearance. Sickle cell screening is required for NCAA athletes (see athletic training forms).

Student's Name _____ **Date of Birth** _____

Height _____ **Weight** _____ **Blood Pressure** _____ **Pulse** _____ **Vision R 20/___ L 20/___ Corrected Y N**

Physical Examination	Normal	Abnormal	Describe Abnormalities
General			
Skin			
HEENT			
Neck/Thyroid			
Chest and Lungs			
Cardiovascular			
Abdomen			
Genitals/Hernia			
Musculoskeletal			
Neurological/Psychiatric			
Other Significant Abnormalities			

Provider Recommendations *(MUST BE COMPLETED):*

- Is this individual currently under treatment for any medical or emotional conditions? Yes☐ No☐
  - If yes, please specify.
- Do you have any recommendations regarding the care of this individual? Yes☐ No☐
  - If yes, please specify.
- Recommendation for physical activity. Unlimited☐ Limited☐
  - If "limited," please specify.

Provider Signature _____ Date of Exam _____
Printed Name _____ MD/DO/NP/PA
Address _____
Telephone _____ Fax _____

Instead of a provider completing this form you may attach documentation of a physical exam but it must include Provider Recommendations/clearance for activities*

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Immunization Record

Name _____ **Date of Birth** _____

Massachusetts state law requires that all full-time students under the age of 30, ALL full- or part-time health science students, and ALL international students submit documentation of the following vaccinations:

****In lieu of a healthcare provider completing and signing this form, you may attach immunization documentation from your healthcare providers office, school or military records)**

Hepatitis B Vaccine #1 Month/Day/Yr _____
Hepatitis B Vaccine #2 Month/Day/Yr _____
Hepatitis B Vaccine #3 Month/Day/Yr _____
(**2 doses of Heplisav-B given on or after 18 years of age is acceptable)
OR Positive blood titer test (Attach lab results) Month/Day/Yr _____

MMR Vaccine #1 (on or after 1st Birthday) Month/Day/Yr _____
MMR Vaccine #2 Month/Day/Yr _____
OR Positive blood titer test (Attach lab results): MM/DD/YR: Measles _____ Mumps _____ Rubella _____
(Non-health science students born before 1957 are not required to complete MMR Documentation)

Tetanus-Diphtheria Acellular Pertussis (on or after 7th birthday) Month/Day/Yr _____
Recommend updated Tdap if greater than 10 years Month/Day/Yr _____

Varicella Vaccine #1 (On or after 1st Birthday) Month/Day/Yr _____
Varicella Vaccine #2 Month/Day/Yr _____
Or:
Reliable history/date of chicken pox Month/Day/Yr _____
(Students born before 1980 are not required to complete varicella documentation)
OR Positive blood titer test (Attach lab results) Month/Day/Yr _____

Meningococcal (MenACWY) (formerly MCV4)- Required for all students under the age of 21. The vaccine must have been given on or after 16th birthday, regardless of housing status. Doses received at younger ages do not count towards this requirement. Month/Day/Yr _____

Meningitis B (2 doses recommended but not required) Month/Day/Yr _____
Month/Day/Yr _____

Failure to comply with Massachusetts immunization law will result in a hold on your registration.

Health Care Provider's Signature _____ **Date** _____
Printed Name _____ MD/DO/PA/NP
Address _____
Telephone _____ **Fax** _____