



Mount Ida College

HEALTH EXAMINATION REPORT

To the Student:

Please fill out Part A and Part B of this Health Examination Report before seeing your physician. It is essential that you return the fully completed form to the Mount Ida College Health Center as soon as possible. This report becomes part of your confidential medical record and will be retained in the College Health Center. A copy of the completed form should be kept by the student.

To the examining Primary Care Provider:

We would appreciate your reviewing in full the student's medical history and performing a complete physical examination as outlined in Part C. Please note that the laboratory tests recommended include hemoglobin, urinalysis and cholesterol. Massachusetts State Law requires that all students attending college provide documentation of immunization for measles, mumps and rubella, tetanus, diphtheria, meningococcal disease and Hepatitis B. Please see back page (Part D) for immunization verification.

The completed form, including immunization documentation, should be mailed directly to:

Mount Ida College Health Center
777 Dedham Street
Newton, Massachusetts 02459
Phone (617) 928-4599 Fax (617) 928-4049

PART A

To be completed by the student.

1. Name _____ Date of Birth ____/____/____
Last First

2. Male Female SS# _____ Place of Birth _____

3. Home Address _____
Number and Street City State Zip Code

4. Parent or Guardian _____
Address

Home Telephone _____ Business Telephone _____

5. Alternate responsible person (not parent) to be reached in case of emergency if Parent or Guardian unavailable

Name Address Telephone

I consent to medical care in the Mount Ida College Health Center.

Date _____

Signature _____ Age _____

If under 18, Parent or Guardian's signature _____

PART B

STUDENT'S MEDICAL HISTORY – To be completed in full by the student.

HAVE YOU EVER HAD OR HAVE YOU NOW (check at RIGHT of each item; if YES, state age):

Check each item	Yes	No	Check each item	Yes	No	Check each item	Yes	No
Neurological			Dental			Digestive		
Concussion			Bleeding gums			Anorexia, bulimia		
Dizzy Spells/fainting			Gum disease			Appendectomy		
Frequent headaches			Poor teeth/toothaches			Chronic abdominal pain		
Insomnia			Wear braces			Colitis, ileitis		
Migraine						Diarrhea, chronic/recurrent		
Seizures/convulsions			Neck			Gall stones		
Severe head injury			Swollen glands often			Hepatitis or jaundice		
						Hemorrhoids		
						Irritable bowel		
Psychiatric			Heart, Lungs			Need special diet		
Recurrent anxiety			Bronchitis			Ulcers		
Recurrent depression			Chest Pain					
Psychiatric treatment			Chronic Cough			Reaction to Medicine		
			Heart murmur/click			Penicillin		
Eyes			Heart disease			Other antibiotics		
Blindness			High blood pressure			Other Medicine		
Color blindness			Palpitation					
Double vision			Pleurisy			Menstrual History		
Injury/disease			Pneumonia			_____ Frequency		
Use glasses/contacts			Shortness of breath			_____ Difficulties		
						_____ Do you take medication? If yes, please state name of medication_____		
Ears, Nose, Throat			Urinary			_____ Do you take birth control pills?		
Deafness, hearing aid			Blood in urine					
Frequent sore throat			Cystitis					
Perforated ear drum			Frequent urination					
Repeated ear infection			Kidney infection					
Repeated nose bleed			Kidney stone					
Sinus trouble			Painful urination					
Strep throat								
Tonsils/adenoids removed								

	Age	State of Health	Age at Death	Cause of Death	Have any of your relatives had any of the following?			
					Yes	No	Relationship	
Father					Allergy, asthma, hay fever			
Mother					Bleeding disorder			
Brothers					Cancer			
					Diabetes			
					Heart Disease			
Sisters					High blood pressure			
					Kidney disease			
					Neuromuscular disorder			
Children					Stomach disease			
					Tuberculosis			
					Other			

PART C

PHYSICIAN'S REPORT

This page is to be completed by a Primary Care Provider within 6 months prior to registration.

I have examined _____ on (date of exam) _____ and found the following

Height _____ Weight _____ BP _____ Pulse _____ Respirations _____

Vision: without glasses Right 20/ ____ Left 20/ ____ with glasses Right 20/ ____ Left 20/ ____

Color vision normal yes no

Hearing: Right normal: yes no Left normal: yes no Hearing aid: yes no

Laboratory tests recommended: Hemoglobin: _____ Gm% Cholesterol: _____ mg%

Urine: Specific gravity: _____ Sugar _____ Protein _____ Microscopic _____

No.	Examination	Normal (yes or no)	List and describe abnormality
1.	Skin, lymphatics		
2.	Head		
3.	Eyes		
4.	Ears		
5.	Nose, throat, teeth		
6.	Neck, Thyroid		
7.	Chest, breast, lungs		
8.	Heart		
9.	Heart murmur		
10.	Abdomen, liver, kidneys, spleen		
11.	Hernia		
12.	Genitalia		
13.	Pelvic/pap (if needed)		
14.	Rectal		
15.	Extremities, back, spine		
16.	Neurological		

List Medications: _____

Indicate Allergies: _____

Applicant is in: excellent good poor health.

The applicant does does not have a history of emotional, psychological or psychiatric disturbance.

The applicant is is not presently under psychotherapy.

Applicant may participate in sports

without restriction with the following restrictions

should not participate in sports. Reasons for limiting activity or sports _____

PRIMARY CARE PROVIDERS SIGNATURE _____

ADDRESS _____

TELEPHONE NUMBER _____ FAX NUMBER _____

PRINT LAST NAME _____ DATE _____

***Please also complete back Immunization Page as required by the State of Massachusetts.**

IMMUNIZATION VERIFICATION – MANDATORY IN MASSACHUSETTS

Immunity is required prior to registration. Please complete and return.

The Information On This Page Is Not Considered ConfidentialTO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. *All information must be in English.*Name _____
Last Name _____ First Name _____**A. M.M.R. (Measles, Mumps, Rubella)** (Two doses required.)1. Dose 1 given at age 12-15 months or later #1 _____ / _____
M Y2. Dose 2 given at age 4-6 years or later, and at least one month after first dose..... #2 _____ / _____
M Y**B. Tetanus-Diphtheria** (Primary series with DTaP or DTP and Booster with Td in the last ten years meets requirement. Tetanus-Diphtheria (Td) booster within the last ten years # _____ / _____
M Y**C. Varicella** (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given a least one month apart if immunized after age 13 years meets the requirement.)

1. History of Disease Yes _____ No _____

2. Varicella antibody _____ / _____ Result: Reactive _____ Non-Reactive _____
M Y

3. Immunization

a. Dose..... #1 _____ / _____
M Yb. Dose #2, given at least one month after first dose, if 13 years or older..... #2 _____ / _____
M Y**D. Hepatitis B** (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)1. Immunization: Dose #1 _____ / _____ #2 _____ / _____ #3 _____ / _____
M Y M Y M Y2. Hepatitis B surface antibody Date _____ / _____ Result: Reactive _____ Non-Reactive _____
M Y**E. Meningococcal** One dose required at entry for freshmen students living in residence halls. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine q3-5yrs. Students who decline the vaccine are required by Massachusetts State Law to complete a waiver.Quadrivalent polysaccharide vaccine Date _____ / _____ Waiver Form completed (declining vaccine)
M Y**F. Tuberculosis Screening**1. Does the student have signs or symptoms of active tuberculosis disease? Yes No
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, check x-ray and sputum evaluation as indicated.2. If the student a member of a high-risk group or is the student entering the health profession? Yes No

If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high risk group.

3. Tuberculin Skin Test: Date Given _____ / _____ / _____ Date Read _____ / _____ / _____
M D Y M D Y

Result _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")

Interpretation (based on mm of induration as well as risk factors): positive negative4. Chest x-ray (required if tuberculin skin test is positive) Result: normal abnormalDate of chest x-ray _____ / _____ / _____
M D Y**Health Care Provider**

Name _____ Address _____

Signature _____ Phone (_____) _____

1 The American College of Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers of Disease Control and the American Thoracic Society. For more information, visit www.acha.org or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or the following web site: www.cdc.gov/nchstp/tb/pubs/corecurr/.2 Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with Aids, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal therapy (e.g. prednisone \geq 15 mg/d for \geq 1 month) or other immunosuppressive disorders.