

❖ PLEASE NOTE ❖

To avoid a registration hold, return the completed Health Report by:

DEADLINES

Fall Semester August 20th
Spring Semester January 12th

If enrolling after the deadline, your Health Report must be submitted by the end of the first week of classes.

A \$50.00 Late Charge will be assessed if these requirements have not been met by the end of the first week of classes.

HEALTH REPORT
PINE MANOR COLLEGE



Health and Wellness Center
400 Heath Street
Chestnut Hill, MA 02467-2332
Phone: 617-731-7171 Fax: 617-731-7559
pmc.edu

TO BE FILLED OUT BY STUDENT

Insurance Information:

Accepting School Insurance?

Yes No

If "No", enter insurance info

Company: _____

Policy No: _____

Group No: _____

ID No: _____

NAME: _____ DATE OF BIRTH: _____
Last First MI Month Day Year

PERMANENT ADDRESS: _____ SOC. SEC #: _____
Street

_____ BIRTHPLACE: _____
City State Zip Country Country

HOME PHONE: _____ (_____) _____ CELL PHONE: _____ (_____) _____
Country Code if International or Area Code Country Code if International or Area Code

EMAIL: _____ Date entering PMC: _____

High School attended: _____ Phone: (_____) _____ Year of graduation: _____

If transferring, college(s) attended: _____ Dates attended: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

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

PRIMARY CARE PROVIDER: _____
Name Phone

CONSENT FOR MEDICAL CARE

Student Signature (if 18 or older) _____ Date _____

PARENT/GUARDIAN SIGNATURE REQUIRED if student is a minor (under 18 years of age)

I hereby grant permission to the Director of Pine Manor College Health Services or authorized representatives, to provide such medical care as my daughter, _____, may require while she is a student at Pine Manor College, including examinations, treatment, immunizations, etc. This also includes referral to outside providers, local hospitals, hospitalization, anesthesia and/or surgery should it be necessary in the event of serious illness or injury and I am not able to be reached.

Name of Parent/Guardian (print) _____ Signature: _____ Date: _____

Valid until student reaches the age of 18 years.

MEDICAL HISTORY

FAMILY HISTORY

	Present Age or Age at Death	State of Health or Cause of Death (good, fair or poor)	Have any of your immediate relatives had any of the following:		
			No	Yes	Relationship
Father			Alcohol/Drug Problem		
Mother			Cancer		
Brothers			Diabetes		
			Heart Disease		
Sisters			High Blood Pressure		
			Kidney Disease		
Spouse			Neurologic Disease		
Children			Mental Illness		
			Tuberculosis		

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

- | | | | |
|--|--|--|--|
| 1. <input type="checkbox"/> Anemia | 10. <input type="checkbox"/> Diabetes (Type ___) | 19. <input type="checkbox"/> Kidney disease/stones | 28. <input type="checkbox"/> Pneumothorax |
| 2. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 11. <input type="checkbox"/> Emotional/mental illness | 20. <input type="checkbox"/> Learning disability/ADD/ADHD | 29. <input type="checkbox"/> Seizure disorder |
| 3. <input type="checkbox"/> Appendectomy | 12. <input type="checkbox"/> Hearing/vision impairment | 21. <input type="checkbox"/> Loss of paired organ (eye,kidney) | 30. <input type="checkbox"/> Sickle cell disease |
| 4. <input type="checkbox"/> Arthritis | 13. <input type="checkbox"/> Heart disease/problem | 22. <input type="checkbox"/> Lupus | 31. <input type="checkbox"/> Thyroid disease |
| 5. <input type="checkbox"/> Asthma | 14. <input type="checkbox"/> Hepatitis (Type ___) | 23. <input type="checkbox"/> Malaria | 32. <input type="checkbox"/> Positive TB test |
| 6. <input type="checkbox"/> Cancer/Malignancy | 15. <input type="checkbox"/> High blood pressure | 24. <input type="checkbox"/> Migraines/chronic headaches | 33. <input type="checkbox"/> Tuberculosis disease |
| 7. <input type="checkbox"/> Chickenpox | 16. <input type="checkbox"/> High cholesterol | 25. <input type="checkbox"/> Mononucleosis | 34. <input type="checkbox"/> Ulcer/stomach problem |
| 8. <input type="checkbox"/> Crohn's/Ulcerative Colitis/IBS | 17. <input type="checkbox"/> HIV infection/disease | 26. <input type="checkbox"/> Neuromuscular disease | 35. <input type="checkbox"/> UTIs (frequent/recurrent) |
| 9. <input type="checkbox"/> Depression | 18. <input type="checkbox"/> Impaired mobility/paralysis | 27. <input type="checkbox"/> Phlebitis/deep vein clot | 36. <input type="checkbox"/> Other _____ |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates) _____

GYNECOLOGICAL HISTORY (Check all that apply):

- Date of last PAP test _____ Result: _____ Have you ever had an abnormal PAP smear? _____ Colposcopy? _____ Date _____
- Irregular periods/no periods Pelvic inflammatory disease (PID) Other sexually transmitted infection (STI/STD) _____
- Polycystic Ovary Syndrome (PCOS) Genital herpes (HSV) Use CONTRACEPTION Pill Other _____
- Breast lumps/fibrocystic disease Genital warts (HPV) Pregnancy (live births) # _____ Abortion/Miscarriage # _____

INPATIENT HOSPITALIZATIONS: Please list all medical and/or psychiatric hospitalizations with dates and diagnoses:

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medications, antidepressants, etc.

ALLERGIES: None known Yes

If yes, please specify, including medications, insect venom, foods, etc. : _____ Type of reaction: _____

1a. Do you exercise? Never Occasionally 3-5 times/week
 Daily 1b. What type of exercise? _____

2a. How tall are you? _____ 2b. How much do you weigh? _____ lbs.
 2c. What is your desired weight? _____ lbs.

3. Would you describe your weight as? Very underweight
 Underweight Just right Overweight Very Overweight

4. Do you do monthly breast self-exam (BSE)? No Yes

5. Do you wear a seatbelt? Always Sometimes Never

6. Do you smoke cigarettes? No Yes How many/day? _____

7. Do you use recreational drugs? No Yes Which ones? _____

8. Do you drink alcohol? No Yes How often? _____
 When you drink, how many do you usually have? _____

9. Are you concerned about your drinking/ drug use? No Yes

10. Do you often feel anxious, overwhelmed, depressed? No Yes

11a. Are you currently seeing a counselor or therapist? No Yes

11b. Have you ever been in therapy? No Yes Dates: _____



PINE MANOR COLLEGE

Health and Wellness Center

400 Heath Street, Chestnut Hill, MA 02467

IMMUNIZATION FORM

Phone: 617-731-7171 • Fax: 617-731-7559

pmc.edu

PART I: (to be completed by student)

NAME : (print)	DATE OF BIRTH:	COUNTRY OF BIRTH:
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PART II: REQUIRED IMMUNIZATIONS (to be completed by a medical provider)

★ The following immunizations are required by Massachusetts Law. All dates must include month/day/year.
 If documentation of immunization is not available or if a blood test indicates that you are NOT immune, you must be re-immunized.
 Attached documents in a language other than English **must be translated into English** by the health care provider.

<p>★ HEPATITIS B (Three doses required)</p> <p>Dose 1: ____/____/____</p> <p>Dose 2: ____/____/____ (Must be at least 1 month after #1)</p> <p>Dose 3: ____/____/____ (Must be at least 2 months after #2 and 4 months after #1)</p> <p>OR Lab test proving immunity (attach lab report)</p> <p><input type="checkbox"/> Immune – Titer value _____ Date: ____/____/____</p>	<p>★ MMR (Measles, Mumps, Rubella)</p> <p>Two doses required, at least one month apart, after 12 months of age</p> <p>Dose 1: ____/____/____ Dose 2: ____/____/____</p> <p>OR Lab test proving immunity (attach lab reports)</p> <p>Measles: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p> <p>Mumps: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p> <p>Rubella: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p>
<p>★ TETANUS/DIPHTHERIA/PERTUSSIS</p> <p>A booster of Tetanus/Diphtheria within last ten years PLEASE NOTE: A one-time dose of Tdap is required, if at least 2-5 years since last Td</p> <p>Td Date ____/____/____ OR Tdap Date ____/____/____</p>	<p>★ MENINGITIS</p> <p><input type="checkbox"/> Date vaccine administered: ____/____/____</p> <p><input type="checkbox"/> Menactra (MCV4) <input type="checkbox"/> Menomune (MPSV4) <input type="checkbox"/> Meningococcal (unspecified)</p> <p>PLEASE NOTE: If primary dose prior to 16 years of age, a booster dose is recommended.</p> <p style="text-align: right;">Date of booster: ____/____/____</p>
<p>★ TUBERCULOSIS RISK ASSESSMENT (RAQ)</p> <p>The Tuberculosis Risk Questionnaire (RAQ) Form must be completed and returned with this form. If your answer to any of the four questions on Page 1 is YES, your health care provider must complete Page 2 of the RAQ. The RAQ can be downloaded at: pmc.edu.</p>	<p>TO BE COMPLETED BY PMC HEALTH SERVICES</p> <p><input type="checkbox"/> LOW RISK <input type="checkbox"/> HIGH RISK <input type="checkbox"/> Hx of positive PPD</p> <p>Date of PPD: ____/____/____ Positive ____ mm Negative <input type="checkbox"/></p> <p>Date of Chest X-ray: ____/____/____ Normal <input type="checkbox"/> Abnormal <input type="checkbox"/></p> <p>INH therapy: Date started: _____ for # _____ months</p>
<p>★ VARICELLA (Chicken Pox)</p> <p>History of Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes at age: ____</p> <p>OR</p> <p>Lab test proving immunity (attach lab report)</p> <p><input type="checkbox"/> Immune Titer value _____ Date: ____/____/____</p> <p>OR</p> <p>Vaccine Dose 1 ____/____/____</p> <p>Vaccine Dose 2 ____/____/____</p>	<p>IMPORTANT NOTICE</p> <p>Failure to comply with the Massachusetts Immunization Law will result in a “HOLD” being placed on your registration. A \$50.00 fee will be assessed for failure to provide the required documentation of immunity by the end of the first week of classes.</p>

PART III: STRONGLY RECOMMENDED IMMUNIZATIONS (to be completed by a medical provider)

<p>HEPATITIS A</p> <p>Hepatitis A Vaccine (at least 6 months apart)</p> <p>Dose 1 ____/____/____ Dose 2 ____/____/____</p> <p>Combined Hepatitis A and B Vaccine</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>	<p>HUMAN PAPILOMAVIRUS (HPV)</p> <p>Vaccine (at 0, 2 and 6 month intervals)</p> <p><input type="checkbox"/> Gardasil <input type="checkbox"/> Other</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>	<p>Health Care Provider</p> <p>Name: _____</p> <p>Signature: _____</p> <p>Date: _____</p>
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PHYSICAL EXAMINATION

A physical examination within the past six months is recommended

STUDENT'S NAME: _____ DATE OF EXAM: _____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Height _____ ft. _____ in. Weight _____ lbs. BMI _____ BP _____ / _____ Pulse _____

Lab work recommended: Hgb/Hct _____ Cholesterol _____ LDL _____ HDL _____ Urine: Glucose: _____ Protein _____ Blood _____

CURRENT MAJOR and CHRONIC PROBLEMS

ACUTE or MINOR PROBLEMS

IF THE STUDENT IS UNDER YOUR CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE US WITH ADDITIONAL INFORMATION TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

ALLERGIES: (medications, insect venom, foods, etc.) _____

Type of Reaction _____ Does the student have an Epi-pen? Yes No

CURRENT MEDICATIONS: _____

Do you have any **dietary recommendations**? No Yes (Please specify): _____

Please note any **additional recommendations** regarding this student: _____

If any **disability-related accommodation** is necessary, a **HOUSING ACCOMODATION REQUEST FORM** must be completed by the physician/psychiatrist and returned to the Director of Residence Life at Pine Manor College. The form can be downloaded at: pmc.edu.

RECOMMENDATIONS for PHYSICAL ACTIVITY Unlimited Limited (specify): _____

Please check the appropriate box above. Students are NOT eligible to practice or participate in intercollegiate sports until this form has been completed and submitted to the Health Center. The athletic trainer and/or coach may have access to the physical examination report of students who elect to participate in athletics.

HEALTH CARE PROVIDER (please print) _____

Address: _____

Phone (____) _____ **FAX** (____) _____

PROVIDER'S SIGNATURE (required) _____

Mail completed form to:
Pine Manor College
Health and Wellness Center
400 Heath Street
Chestnut Hill, MA 02467-2332
Fax: 617-731-7559