

❖ 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
www.pmc.edu/wellness-center

FOR PMC STAFF USE ONLY

COMPLETE: Date: _____

ALLERGIES:

OTHER:

- MMR #1 #2 Titer
- Hepatitis B #1 #2 #3 Titer
- Td Tdap Varicella
- Meningitis: Vaccine Waiver
- PPD: N/A Neg Pos
- Chest X-ray INH
- Athletic Clearance Exemption

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

E-MAIL: _____ 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"/> Deaf/hearing impairment | 19. <input type="checkbox"/> Impaired mobility/paralysis | 28. <input type="checkbox"/> Pneumothorax |
| 2. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 11. <input type="checkbox"/> Depression | 20. <input type="checkbox"/> Kidney disease/stones | 29. <input type="checkbox"/> Seizure disorder |
| 3. <input type="checkbox"/> Appendectomy | 12. <input type="checkbox"/> Diabetes | 21. <input type="checkbox"/> Learning disability/ ADD/ADHD | 30. <input type="checkbox"/> Sickle cell disease |
| 4. <input type="checkbox"/> Arthritis | 13. <input type="checkbox"/> Emotional/mental illness | 22. <input type="checkbox"/> Loss of paired organ (eye, kidney) | 31. <input type="checkbox"/> Thyroid disease |
| 5. <input type="checkbox"/> Asthma | 14. <input type="checkbox"/> Heart disease/problem | 23. <input type="checkbox"/> Malaria | 32. <input type="checkbox"/> Positive TB test |
| 6. <input type="checkbox"/> Blind/Visual impairment | 15. <input type="checkbox"/> Hepatitis (Type ____) | 24. <input type="checkbox"/> Migraines/chronic headaches | 33. <input type="checkbox"/> Tuberculosis disease |
| 7. <input type="checkbox"/> Cancer/malignancy | 16. <input type="checkbox"/> High blood pressure | 25. <input type="checkbox"/> Mononucleosis | 34. <input type="checkbox"/> Ulcer/stomach problem |
| 8. <input type="checkbox"/> Chickenpox | 17. <input type="checkbox"/> High cholesterol | 26. <input type="checkbox"/> Neuromuscular disease | 35. <input type="checkbox"/> UTIs (frequent/recurrent) |
| 9. <input type="checkbox"/> Crohn's/Ulcerative Colitis/IBS | 18. <input type="checkbox"/> HIV infection/disease | 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 or drug use? No Yes

10. Do you often feel anxious, overwhelmed or 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

PART I: (to be completed by student)

Form with fields for NAME (print), DATE OF BIRTH, SS #, and COUNTRY OF BIRTH.

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.

Grid of immunization requirements including HEPATITIS B, MMR (Measles, Mumps, Rubella), TETANUS/DIPHTHERIA/PERTUSSIS, and MENINGITIS.

Grid containing TUBERCULOSIS RISK ASSESSMENT (RAQ) and TO BE COMPLETED BY PMC HEALTH SERVICES.

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

Grid of recommended immunizations including VARICELLA (Chicken Pox), HEPATITIS A, and HUMAN PAPILLOMAVIRUS (HPV).

Health Care Provider (please print) _____ (sign) _____

❖ IMPORTANT NOTICE ❖

Failure to comply with the Massachusetts Immunization Law will result in a hold being placed on your registration. A \$50.00 late fee will be assessed for failure to provide the required documentation of immunity by the end of the first week of classes.

PHYSICAL EXAMINATION

A physical examination within the past six months is required

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: <http://community.pmc.edu/healthandwellness/forms.htm>

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:
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