Pine Manor College

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, Pine Manor College REQUIRES all students have on file a completed Immunization Form. **Any student failing to comply MAY NOT BE PERMITTED TO REGISTER FOR CLASSES OR LIVE IN THE RESIDENCE HALLS.** The Immunization Form must be filled out by a medical provider.

HEALTH REPORT
Pine Manor College

Office of Student Affairs
400 Heath Street
Chestnut Hill, MA 02467-2332
Phone: 617-731-7151 Fax: 617-731-7102

For PMC STAFF USE ONLY

☐ **COMPLETED:**

ALLERGIES:
OTHER:
MMR: #1 ☐ #2 ☐ Titer ☐

Hepatitis B: #1 ☐ #2 ☐ #3 ☐ Titer ☐
Tdap: ☐
Varicella: #1 ☐ #2 ☐ #3 ☐ Titer ☐
Hx dz ☐
Meningitis: Vaccine ☐ Waiver ☐
PPD: N/A ☐ Neg ☐ Pos ☐
Chest X-ray ☐ INH ☐

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

PERMANENT ADDRESS: _____ **SOC. SEC #:** _____
Street

_____ **BIRTH PLACE:** _____
City State Zip Country Country

GENDER: Female ☐ Male ☐ Transgender ☐ Other ☐

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 HS graduation _____
Country Code if International or Area Code

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

Email address: _____
PRIMARY CARE PROVIDER: _____
Name Phone

CONSENT FOR MEDICAL CARE

Student Signature (if 18 older)_____ Date _____

PARENT/GUARDIAN SIGNATURE REQUIRED if student is a minor (under 18 years of age)
I hereby grant permission to Pine Manor College's authorized representatives, to provide/seek medical care as my child, _____, may require while attending Pine Manor College. This includes referrals to outside providers, local hospitals, hospitalizations, 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):

- ☐ Anemia
- ☐ Anorexia nervosa/bulimia
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer/malignancy
- ☐ Chickenpox
- ☐ Crohn's/ulcerative colitis/IBS
- ☐ Depression
- ☐ Diabetes (Type___)
- ☐ Emotional/mental illness
- ☐ Deaf/hearing impairment
- ☐ Heart disease /problem
- ☐ Hepatitis (Type___)
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV infection/disease
- ☐ Impaired mobility/paralysis
- ☐ Kidney disease/stone
- ☐ Learning disability/ADD/ADHD
- ☐ Loss of paired organ
- ☐ Blind/visual impair
- ☐ Malaria
- ☐ Migraines/chronic headaches
- ☐ Mononucleosis
- ☐ Neuromuscular disease
- ☐ Phlebitis/deep vein clot
- ☐ Pneumothorax
- ☐ Seizure disorder
- ☐ Sickle Cell
- ☐ Thyroid disease
- ☐ Positive TB test
- ☐ Tuberculosis
- ☐ Ulcer/stomach issues
- ☐ UTIs (frequent)
- ☐ Other_____

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates):

_____

_____

GYNECOLOGICAL HISTORY

(Check all that apply):

Date of PAP test_____ Result: _____ Have you ever had an abnormal PAP smear? _____ Colposcopy? _____ Date _____

- ☐ Irregular periods /no periods
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Breast lumps/fibrocystic
- ☐ Contraction: Pill___ Other____
- ☐ Genital herpes (HSV)
- ☐ Genital warts (HPV)
- ☐ Other sexually transmitted infections _____
- ☐ Pelvic inflammatory disease
- ☐ Pregnancy: live births #_____ Abortion/miscarriage #_____

IN-PATIENT HOSPITALIZATIONS (Please list all medical and/or psychiatric hospitalizations with dates and diagnosis):

_____

_____

MEDICATIONS: Please list all (prescriptions 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_____

How tall are you?_____

How much do you weigh? _____

Do you smoke cigarettes? ☐ No ☐ Yes

How many/day? _____

Are you concerned about your drinking use? ☐ No ☐ Yes

Do you drink alcohol? ☐ No ☐ Yes

How often? _____

When you drink, how many do you usually have?

_____

Are you concerned about your drug use? ☐ No ☐ Yes

Do you use recreational drugs? ☐ No ☐ Yes

Which ones? _____

Do you often feel anxious or depressed? ☐ No ☐ Yes

Are you currently seeing a counselor/therapist? ☐ No ☐ Yes

Have you ever been to therapy? ☐ No ☐ Yes

Dates: _____

Do you exercise? ☐ Never ☐ 3-5 times/week ☐ Daily

What type of exercise? _____