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

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IMMUNIZATION FORM

PART I: (to be completed by student)

NAME : (print)	**DATE OF BIRTH:**	**SS #:**
COUNTRY OF BIRTH:	**If not born in USA, year entered the country: _____**	

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.

★HEPATITIS B (Three doses required)

Dose 1: _____/_____/_____

Dose 2: _____/_____/_____ (Must be at least 1 month after #1)

Dose 3: _____/_____/_____ (Must be at least 2 months after #2 and 4 months after #1)

OR Lab test proving immunity (attach lab report)

☐ Immune – Titer value _____ Date: _____/_____/_____

★MMR (Measles, Mumps, Rubella)

Two doses required, at least one month apart, after 12 months of age

Dose 1: _____/_____/_____ Dose 2: _____/_____/_____

OR Lab test proving immunity (attach lab reports)

Measles: ☐ Immune - Titer value _____ Date: ____/____/____
Mumps: ☐ Immune - Titer value _____ Date: ____/____/____
Rubella: ☐ Immune - Titer value _____ Date: ____/____/____

★TETANUS/DIPHTHERIA/PERTUSSIS

A booster of Tetanus/Diphtheria within last ten years
PLEASE NOTE: A one-time dose of Tdap is recommended, if at least 2-5 years since last Td

Td Date ____/____/____ **OR** Tdap Date ____/____/____

★MENINGITIS

☐ Date vaccine administered: _____/_____/_____
☐ Menactra (MCV4) ☐ Menomune (MPSV4) ☐ Meningococcal (unspecified)

OR ☐ WAIVER, if not immunized, must be signed and returned with this form. Waiver can be downloaded at: http://community.pmc.edu/healthandwellness/MeningWaiver.doc

★ TUBERCULOSIS RISK ASSESSMENT (RAQ)

The enclosed **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: http://community.pmc.edu/healthandwellness/tbrisk.pdf

TO BE COMPLETED BY PMC HEALTH SERVICES

☐ **LOW RISK** ☐ **HIGH RISK** ☐ **Hx of positive PPD**

Date of PPD: ____/____/____ ☐ Positive ____mm ☐ Negative

Date of Chest X-ray: ____/____/____ ☐ Normal ☐ Abnormal

INH therapy ☐ No ☐ Yes Date started: _____ for #_____months

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

VARICELLA (Chicken Pox)

History of Disease: ☐ No ☐ Yes at age: ____
OR
Lab test proving immunity (attach lab report)
☐ Immune Titer value ____ Date: ___/___/___
OR
Vaccine Dose 1 _____/_____/_____
Vaccine Dose 2 _____/_____/_____

HEPATITIS A

Hepatitis A Vaccine (at least 6 months apart)
Dose 1 ___/___/___ Dose 2 ___/___/___

Combined Hepatitis A and B Vaccine
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

HUMAN PAPILLOMAVIRUS (HPV)

Vaccine (at 0, 2 and 6 month intervals)
☐ Gardasil ☐ Other

Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

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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400 Heath Street
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