

Health Services
 St. Mary's College of Maryland
 18952 E. Fisher Road
 St. Mary's City, Maryland 20686
 Phone: 240-895-4289 Fax: 240-895-4937

Reviewed by: _____
 Date: _____
 SID: _____

INSTRUCTIONS AND INFORMATION:

1. The primary purpose of this form is to provide a means of identifying and attending to students with medical problems or special needs and to assure that immunizations are current, thereby reducing public health risks on campus. **Your health care provider MUST sign this form.**
2. Completion of the form is mandatory for all full-time students. Return the original form at least 3 weeks PRIOR to coming to campus. You will not be able to receive services without a completed health form.
3. Information on this form will not affect admission status. It is confidential and for Health Services use only. No information will be released without the student's written consent.
4. Please bring your insurance and prescription cards to campus.
5. Complete all information in English.
6. International students and teaching assistants MUST report to Health services upon arrival to campus.
7. Health Services does not arrange for student transportation to facilities off campus, except in the case of an emergency.
8. Each student is responsible for his/her own health insurance. Laboratory work done by an outside lab, x-rays, emergency services and hospitalization are not covered by student fees.

SSN _____ Birth Date _____ SEX M _____ F _____

 Last Name First Name Middle

 Home Address City/Town State Zip Code

 Name and Relationship of person to be notified in case of emergency (H) Telephone (W)

 Insurance Company Address Phone

 Policy Holders Name Group # Policy #

I. MEDICAL HISTORY

1. List any medical condition for which you have been or are being treated currently.
 Condition Year Diagnosed Treatment

2. List any operations or hospitalizations you have had.
 Problem Date

3. List all medications you are now taking (including prescriptions, over-the-counter medications, nutritional supplements, and oral, injectable or implantable hormonal contraception).
 Name Dosage How Often

4. List your allergies (including, but not limited to, medication, food, environment or insects):
 Type Reaction

CHECK HERE IF YOU WILL BE RECEIVING ALLERGY SHOTS WHILE AT COLLEGE (you will be sent an information packet).

II. **FAMILY HISTORY** Were you adopted? Yes _____ No _____

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Sister/s					
Brother/s					

III. IMMUNIZATIONS RECORD Below immunizations are **REQUIRED FOR ALL FULL-TIME STUDENTS**. Your physician, high school or local health department may be able to provide documentation of your vaccinations. Religious or medical exemption can be granted if appropriate.

A. Tetanus-Diphtheria-Pertussis preferred Please indicate if Td only is given.

1. Booster within the last 10 years..... Mo. / Day / Yr.

B. M.M.R. (Mumps, Measles, Rubella) (2 doses required at least 28 days apart or positive immune titer)

1. Immunization..... Dose #1 Mo. / Day / Yr. Dose #2 Mo. / Day / Yr.

2. Positive immune titer date..... Mo. / Day / Yr.

C. Varicella (Birth in U.S. before 1980, history of chicken pox, positive immune titer, or 2 doses of vaccine meets the requirement)

1. History of disease? Yes ___ No ___ **OR** Birth in U.S. before 1980 Yes ___ No ___

2. Antibody test..... Mo. / Day / Yr. Result: Reactive ___ Non-reactive ___

3. Immunization..... Dose #1 Mo. / Day / Yr. Dose #2 Mo. / Day / Yr. at least 12 weeks after Dose 1 age 1-12 years and Dose 2 at least 4 weeks after 1st dose 13 years or older

D. Hepatitis B (three doses required or proof of reactive surface antibody) Two doses required prior to starting college.

1. Immunization..... Dose #1 Mo. / Day / Yr. Dose #2 Mo. / Day / Yr. Dose #3 Mo. / Day / Yr.

2. Positive surface antibody date..... Mo. / Day / Yr. Result: Reactive ___ Non-reactive ___

E. Polio

1. Date of last booster..... Mo. / Day / Yr.

F. Tuberculosis Screening ¹ (MUST BE PERFORMED and FORM SIGNED BY HEALTH CARE PROVIDER.) F1 and F2 MUST both be answered.

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, chest x-ray, and sputum evaluation as indicated.

2. Is the student a member of a high risk group or is the student entering the health professions? ² YES ___ NO ___

If YES, place Mantoux skin test. A history of BCG vaccination should not preclude testing for a member of a high-risk group.

3. Tuberculin skin test:..... Date given Mo. / Day / Yr. Date read Mo. / Day / Yr.

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 ___ negative ___

4. Date of chest x-ray (required if tuberculin skin test is positive) Mo. / Day / Yr. Result: normal ___ abnormal ___

1. The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for 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 at 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 those with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunioileal by-pass, chronic malabsorption syndromes, prolonged corticosteroids therapy (e.g. prednisone ≥ 15mg/d for ≥ 1month) or other immunosuppressive disorders.

G. Meningococcal: I have received the meningococcal vaccine as required by Maryland law for individuals residing in on-campus student housing at an institution of higher education. (If requesting an exemption to the meningococcal vaccine requirement, complete the Meningococcal Waiver form).

Tetavalent conjugate preferred..... Date Mo. / Day / Yr.

Tetavalent polysaccharide (acceptable alternative if conjugate not available, revaccinate every 3-5 years if increased risk continues) Date Mo. / Day / Yr.

IV. PERMISSION FOR TREATMENT AND VERIFICATION OF INFORMATION

If you are 18 years or older (or will be by time of arrival at school), please sign form yourself:

I grant permission to the health services physician (or designee) to hospitalize and secure treatment for me in the event of any, medical, surgical, or psychiatric emergency if I am unconscious or incompetent at the time of, for any reason including but not limited to, an accident or self-induced process. I hereby certify that the information provided on this form is accurate to the best of my knowledge.

Signature of student _____ Date _____

If you are UNDER 18 years, parent or guardian must also sign form:

I grant permission to the health services physician (or designee) to hospitalize and secure treatment for my son, daughter or ward in the event of medical, surgical, or psychiatric emergency, provided the physician is unable to contact me reasonably soon and if, in his/her professional judgment, further delay would jeopardize the patient's health. I hereby certify that the information provided on this form is accurate to the best of my knowledge.

Signature of parent or guardian _____ Date _____

Signature of student _____ Date _____

HEALTH CARE PROVIDER (Physician, Physician Assistant, Nurse Practitioner or RN)

Name _____ Address _____

Please Print

Signature _____ Phone () _____

Signature Required