SMCM Health Center Required Info

**DO’S AND DON’TS**

This is the busiest time of the year for Health Services. Reviewing health records is a time consuming process. To help make the college transition run smoothly for you and the health services staff, please read the following Do’s and Don’ts PRIOR to filling out the packet.

**DO**

- **DO** have Parents/Students fill out pages 1 & 2 and a health provider **MUST** fill out pages 3 & 4.
- **DO** schedule your immunizations in a timely manner to reach our deadline which is June 1st for the fall semester and December 30th for the spring semester.
- **DO** double-check contents of all forms to make sure they are complete, especially the signatures and dates.
- **DO** make sure you specify “Health Services” on your return envelope if you are mailing your forms back to us.
- **DO** make copies of all forms before bringing or mailing the original forms to Health Services. Health Services will only keep your medical records for 5 years.
- **DO** attach a copy of your insurance card, front and back.

**DON’T**

- **DON’T** turn in your medical records to anyone other than Health Services staff.
- **DON’T** mail your athletic medical forms (if you’re an athlete) to Health Services and vice versa…we are separate departments and, therefore, cannot share confidential information.
- **DON’T** submit your health history form with other Admissions materials.
- **DON’T** fax your completed medical package to Health Services. Because medical records are confidential and fax quality is never guaranteed, we require the original forms.
- **DON’T** call Health Services to verify receipt of your information…our staff will notify you by phone or email if something is missing. Please check your student portal for status of forms.

**FAILURE TO COMPLETE THE HEALTH HISTORY FORM WILL RESULT IN A MEDICAL HOLD BLOCKING REGISTRATION FOR CLASSES AND HOUSING!!!**
Student Health Services
St. Mary’s College of Maryland
18952 E. Fisher Rd
St. Mary’s City, MD  20686
PHONE: 240-895-4289/FAX: 240-895-4937

Deadline:  June 1st for the Fall Semester and January 1st for the Spring Semester

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<table>
<thead>
<tr>
<th>Last Name</th>
<th>First</th>
<th>Middle</th>
<th>DOB</th>
<th>Age</th>
<th>Student ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>Preferred Pronoun</td>
<td>Social Security #</td>
<td>Student Cell Phone #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Address (Number &amp; Street)</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
<td>Home Phone #</td>
<td></td>
</tr>
<tr>
<td>Name of Parent or Guardian for Emergency Contact</td>
<td>Cell Phone #</td>
<td>Home Phone #</td>
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<tr>
<td>Insurance Company</td>
<td>Address</td>
<td>Phone #</td>
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<tr>
<td>Policy Holder’s Name</td>
<td>Policy #</td>
<td>Group #</td>
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Please list primary Physician(s) or other Specialists:

<table>
<thead>
<tr>
<th>Name</th>
<th>Specialty</th>
<th>Address (City/State)</th>
<th>Phone #</th>
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</thead>
</table>

PERSONAL MEDICAL HISTORY
You must complete each line.  Please indicate “NO” or “NONE” on each line or section that does not apply to you.

DO YOU HAVE ALLERGIES?  YES    (If “yes”, please list below)  No    EPI-PEN?  Yes    No

Medications you are allergic to and REACTION:

Other (food, insect stings, etc.) and REACTION:

☐ Check here if you will be receiving allergy shots at St. Mary’s College of Maryland. An allergy packet will be mailed to you for completion.

Please list any illness or medical condition for which you are being treated  OR NONE

Condition | Year Diagnosed | Treatment
|-----------|---------------|--------|
Please list any operations or hospitalizations you have had OR NONE □
Reason    Hospital    Date

Please list all medication you are now taking (including over the counter meds, birth control pills, allergy serum, antidepressants, vitamins) OR NONE □
Name of Medication    Dose    How often taken

Family History
Are you adopted? Yes □  No □

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>State of Health</th>
<th>Occupation</th>
<th>Age at Death</th>
<th>Cause of Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
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<tr>
<td>Brother(s)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Sister(s)</td>
<td></td>
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</table>

Have you had any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Hospitalized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal pain</td>
<td></td>
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</tr>
<tr>
<td>Asthma</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>STD’s</td>
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<td></td>
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<tr>
<td>Mental Illness/Depress</td>
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<tr>
<td>Alcohol/Drug Use</td>
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<td></td>
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<tr>
<td>Tobacco Use</td>
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<td></td>
<td></td>
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<tr>
<td>Eating Disorder</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Other:</td>
<td></td>
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<td></td>
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</table>

SIGNATURE REQUIRED

Counseling and Health Center Consent
I understand that the health care information provided by me here and gathered at visits to the SMCM Counseling and Health Center is confidential. I agree that all such healthcare information may be used and shared by the providers in the Counseling and Health Center to ensure a continuity of care with issues that require medical and psychological co-management and I authorize them to share this information. I hereby waive any and all claims against SMCM and its employees arising from the use and sharing of such information. I understand that my health care information will not be shared outside the Counseling and Health Center without my consent.

Signed by student                                        Date

SIGNATURE REQUIRED

Authorization for SMCM Health Center and neighboring hospitals
(To be signed by a parent or guardian if student is a minor OR by student if 18 years of age or older)
If I require emergency treatment at SMCM Health Center or neighboring hospitals AND I AM UNABLE TO PROVIDE CONSENT TO TREATMENT, I hereby give permission for emergency medical treatment, INCLUDING SURGERY, which the attending physician considers necessary.

If A MINOR IS INVOLVED, ordinarily the attending physician will ATTEMPT TO CONTACT the parent or guardian before major surgery is performed. WHERE A MINOR IS INVOLVED, this permission RELATES to an emergency in which the parent or guardian cannot be contacted AND DELAYING THE TREATMENT OR SURGERY POSES a serious RISK to the student.

Signed                                          Date
Student Signature or Parent/Guardian of Minor Student
SMCM Health Services – Immunization Record

ALL DATES TO BE COMPLETED BY HEALTH CARE PROVIDER – COPIES OF RECORDS OR “SEE ATTACHED” NOT ACCEPTED (ALL IMMUNIZATIONS AND TUBERCULIN SKIN TEST DOCUMENTATION MUST BE SUBMITTED IN ENGLISH)

(Student’s) Last Name ______________________  First Name ______________________  DOB ______________________

Provider’s Name ______________________  Signature ______________________  Date ______________________

Address ______________________  Phone ______________________

PLEASE PROVIDE THE MONTH/DAY/YEAR FOR THE FOLLOWING REQUIRED VACCINATIONS:

MMR – Measles, Mumps Rubella Required by ALL students unless born in the US before 1957
Two doses required or a blood titer to show immunity to the disease

MMR Dose #1: Date ______/_____/______  OR  Lab test proving immunity (attach lab reports)

Must be given after 1st birthday

Measles ☐ Immune – titer value ______ Date ______/_____/______

MMR Dose #2: Date ______/_____/______

At least one month after 1st dose

Mumps ☐ Immune – titer value ______ Date ______/_____/______

Rubella ☐ Immune – titer value ______ Date ______/_____/______

Tdap – TETANUS-DIPTHERIA-PERTUSSIS Required by ALL students unless Td in past 10 years
Highly recommend Tdap even if student meets Td requirement

☐ Tdap  Date ______/_____/______  OR  ☐ Td  Date ______/_____/______

HEPATITIS B Required by ALL students

☐ 3-dose series

Hepatitis B Dose #1 Date ______/_____/______

Hepatitis B Dose #2 Date ______/_____/______

Must be at least 1 month after #1

Hepatitis B Dose #3 Date ______/_____/______

Must be 6 months after #1 dose

OR

☐ 2-dose adolescent series

OR

☐ Lab test proving immunity (attach lab report)

□ Immune-titer value & date

□ 2-dose 10 mcg series accepted with proper documentation. There must be a 4 month minimum interval between dose 1 and 2.

Hepatitis Dose #1 Date ______/_____/______

Hepatitis Dose #2 Date ______/_____/______

☐ Recombivax  ☐ Merck

VARICELLA-CHICKENPOX Required for ALL students unless born in the US before 1980

☐ Varicella Dose #1 Date ______/_____/______

Must be given after first birthday

☐ Varicella Dose #2 Date ______/_____/______

At least one month after first dose

OR

Lab test proving immunity (attach lab report)  OR  ☐ Reliable history of

□ Immune-Titer value ______ Date ______/_____/______

□ chickenpox disease

MENINGITIS Required for ALL residential students
(given after age 16 or within past 3 years)

Meningitis Vaccine Date ______/_____/______

☐ Menactra (MCV4)  ☐ Menomune (MPSV4)  ☐ Meningococcal (unspecified)

POLIO Required for ALL residential students

Date of last booster ______/_____/______

GARDISIL (optional)

Dose #1 Date ______/_____/______

Dose #2 Date ______/_____/______

Dose #3 Date ______/_____/______
SMCM Health Service – Tuberculosis Screening

TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY

Tuberculosis screening is required of all students entering SMCM, based upon guidelines of the American College Health Association and the U.S. Centers for Disease control. For more information, see [www.acha.org](http://www.acha.org) or [www.cdc.gov/tb](http://www.cdc.gov/tb).

(Student’s) Last Name ___________________________ First ___________________ M _______ DOB ____________

Provider’s Name ___________________________ Signature ___________________________ Date ____________

1. Does the student have signs or symptoms of active tuberculosis disease? Y ( ) or N( )
   - Unexplained elevation of temperature for more than one week, weight loss, night sweats, persistent cough for more than three weeks
   - Cough with production of bloody sputum (hemoptysis)

2. Has the student ever had a positive Tuberculin Skin Test (TST, formerly PPD) or Quanti-FERON Tb Test? Y ( ) or N( )

3. Is the student a member of a high risk group? Y ( ) or N( )
   - Had close contact with a know case of active tuberculosis
   - Use of illegal injected drugs
   - Currently on immunosuppressive therapy
   - Resident or employee of a nursing home, homeless shelter or correctional facility

4. Has the student lived or traveled in countries where Tb is endemic? Y ( ) or N( )
   - Includes students who have arrived in the US in the past five years from countries OTHER THAN:
     Albania, American Samoa, Andorra, Antigua, Barbuda, Australia, Austria, Barbados, Belgium, Bermuda, British Virgin Islands, Canada, Cayman Islands, Chile, Cook Island, Costa Rica, Cuba, Cyprus, Czech Republic, Denmark, Dominica, Finland, France, Germany, Greece, Grenada, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Jordan, Lebanon, Libyan Arab Jamahiriya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts & Nevis, Saint Lucia, Somoa, San Marino, Slovakia, Slovenía, Sweden, Switzerland, Trinidad and Tobago, Turks and Caicos Islands, United Arab Emirates, United Kingdom, U.S., U.S. Virgin Islands.

*IF THE ANSWER TO ALL THE ABOVE QUESTIONS IS NO, NO FURTHER TESTING OR ACTION IS REQUIRED.

*IF THE ANSWER TO ANY QUESTIONS ABOVE IS YES, THE STUDENT MUST UNDERGO TUBERCULIN SKIN TESTING, QUANTI-FERON TB TESTING, AND/OR CHEST X-RAY AS INDICATED, DOCUMENTED BELOW:

<table>
<thead>
<tr>
<th>Tuberculin Skin Test: Date Placed</th>
<th>Date read</th>
<th>Results</th>
<th>mm</th>
</tr>
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<tbody>
<tr>
<td>Quanti-FERON Test: Results: Positive ( ) Negative ( )</td>
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</tbody>
</table>

Chest x-ray (required if current or previous TST or QFT test is positive):
| Date: ____________________________ | Normal ( ) | Abnormal ( ) |

INH Treatment: Initiate Date ____________________________ X ____________ months Declined ( )