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

____ (H)__________________________(W)______________________

Name and Relationship of person to be notified in case of emergency Telephone

____

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______/_____/______ Dose #2______/_____/_____
Mo. Day Yr. 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 ……………_____/_____/_____ Result: Reactive_______ Non-reactive______
Mo. Day Yr.
3. Immunization……….Dose #1______/______/_______ Dose #2_____/______/______ at least 12 weeks after Dose 1 age 1-12 years and
Mo. Day Yr. Mo. Day Yr. 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______/______/_______ Dose #2______/______/______ Dose #3_______/______/______
Mo. Day Yr. Mo. Day Yr. Mo. Day Yr.
2. Positive surface antibody date……….._______/_______/________ Result: Reactive__________ Non-reactive__________
Mo. Day Yr.

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______/______/______…………………Date read______/______/______
Mo. Day Yr. 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) ____/____/____ Result: normal_____ abnormal_____
Mo. Day Yr.

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 jejunoileal 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 Wavier form).

Tetravalent conjugate preferred…………… Date______/______/______
Mo. Day Yr.

Tetravalent 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

Revised 11.2007