SMCM Health Center Information

STUDENT HEALTH RECORD PORTAL ***https://smcm.medicatconnect.com/***

All students have access to a patient portal in our electronic health records. Use the link above and enter the *smcm.edu email* *and* *password* assigned to the student by the college. Be sure you can access this portal before coming to campus.
If you have difficulty accessing the portal a paper copy will be accepted.

1. **Required** by the State of Maryland for all **residential** students:
    a. Verification of Meningitis Vaccine or Waiver https://docs.google.com/forms/d/e/1FAIpQLSfGtai1r3IsoK9m_EGg8UvqtofoyybKmHLWPqA9q81aouulJg/viewform
    b. A student **will not** be allowed to move into a residence hall if the Meningitis information has not been completed with the Wellness Center.

2. Requested by the Wellness Center health care providers before health services are accessed**.** ***Care will not be withheld in an emergency.***
    a. Medical history completed via portal
    b. Signed Authorization to Treat form (must be signed by parent/guardian if student is under 18 years of age)
    c. Immunization records uploaded to portal
    d. Copy of insurance card uploaded to portal

3. Requested when a student accesses health care:
    a. Current Insurance card. If students has no insurance we will work to reduce out-of-pocket expenses for labs and prescriptions
    b. Name and date of birth for OWNER of insurance policy

4. St. Mary's College of Maryland DOES NOT require a student to have medical insurance.
    a. We do not charge for health or counseling appointments.
    b. If a student requires laboratory testing or a prescription it may incur out-of-pocket costs or we will bill insurance.
    c. If you are interested in purchasing insurance please refer to the Wellness Center web page on the college website. www.smcm.edu/Wellness/

Wellness Center, Health Services
St. Mary's College of Maryland
47645 College Drive
St. Mary's City, MD 20686
PHONE: 240-895-4289/FAX: 240-895-4937

Legal Last Name First Middle DOB Age Student ID #

Gender Preferred Name and Pronoun Social Security # Student Cell Phone #

Home Address (Number & Street) City State Zip Code Home Phone #

Name of Parent or Guardian for Emergency Contact Cell Phone # Home Phone #

Insurance Company Address Phone #

Policy Holder's Name Policy # Group #

Please list primary Physician(s) or other Specialists:

Name Specialty Address (City/State) Phone #

PERSONAL MEDICAL HISTORY

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, antidepressant and vitamins) **OR** **NONE** ☐

Name of Medication Dose How often taken

Family History

Are you adopted**? Yes** ☐ **No** ☐

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

Have you had any of the following?

	Yes	No	Hospitalized
Abdominal pain			
Asthma			
Cancer			
Diabetes			
High Blood Pressure			
STD's			
Mental Illness/Depress			
Alcohol/Drug Use			
Tobacco Use			
Eating Disorder			
Other:			

SIGNATURE REQUIRED

Health Center Consent

I understand that the health care information provided by me here and gathered at visits to the SMCM Health Center is confidential. I agree that all such healthcare information may be used and shared by the providers in the Wellness 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 Wellness 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 – Suggested Immunization Record

(PLEASE SUBMIT 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 RECOMMENDED VACCINATIONS

MMR – Measles, Mumps Rubella **Recommended for 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 _____/_____/_____ **Mumps** ☐ **Immune – titer value** _____ **Date** _____/_____/_____

At least one month after 1st dose **Rubella** ☐ **Immune – title value** _____ **Date** _____/_____/_____

Tdap – TETANUS-DIPTHERIA-PERTUSSIS **Suggested for ALL students unless Td in past 10 years**

Highly recommend Tdap even if student meets Td requirement

☐ **Tdap Date** _____/_____/_____ **OR** ☐ **Td Date** _____/_____/_____

HEPATITIS B **Recommended for ALL students**

☐ **3-dose series** **OR** ☐ **2-dose adolescent series** **OR** **Lab test proving immunity (attach lab report)**

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

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**

☐ **Immune-titer value & date**

_____

POLIO **Recommended for ALL residential students**

Date of last booster _____/_____/_____

GARDISIL (optional)

Dose #1 Date_____/_____/_____ **Dose #2 Date**_____/_____/_____ **Dose #3 Date**_____/_____/_____

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

☐ **Varicella Dose #1 Date** _____/_____/_____ **OR** **Lab test proving immunity (attach lab report)** **OR** ☐ **Reliable history of chickenpox disease**

Must be given after first birthday

☐**Varicella Dose #2 Date** _____/_____/_____

At least one month after first dose

☐ **Immune-Titer value** _____

Date _____/_____/_____

MENINGITIS

Required for ALL residential students (OR WAIVER MUST BE SIGNED) entire information at

https://docs.google.com/forms/d/e/1FAIpQLSfGtai1r3IsoK9m_EGg8Uvqtofoyybkmhlwpqa9q81aouulJg/viewform

(given after age 16 or within past 5 years)

Meningitis Vaccine Date_____/_____/_____ ☐ **Menactra (MCV4)** ☐ **Menomune (MPSV4)** ☐ **Meningococcal (unspecified)**

I/my child (under 18) choose to waive the state required MENINGITIS vaccine: _____

SMCM Health Service – Tuberculosis Screening

Tuberculosis screening is recommended for 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 or 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 Jamahihiya, Luxembourg, Malta, Monaco, Montserrat, Netherlands, Netherlands Antilles, New Zealand, Norway, Puerto Rico, Saint Kitts & Nevis, Saint Lucia, Somoa, San Marino, Slovakia, Slovinia, 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:**

Tuberculin Skin Test: Date Placed _____ **Date read** _____ **Results** _____**mm**

Quanti-FERON Test: Results: Positive ( ) Negative ( )

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

INH Treatment: Initiate Date _____ **X** _____ **months** **Declined ( )**