HEALTH REPORT: Students should complete the first two pages before presenting the form to their healthcare provider.

DEADLINES

JUNE 28
FALL SEMESTER

JANUARY 15
SPRING SEMESTER

ALL students are required to return the Health and Immunization Report to Health Services by the deadline.

MAIL ALL DOCUMENTS TO:
Stonehill College Health Services
320 Washington Street
Easton, MA 02357-5710
Phone: 508-565-1307
Fax: 508-565-1510
www.stonehill.edu/health

Please make a copy for your records.

FOR HEALTH SERVICES USE ONLY
Date received:
All requirements complete: Y N

STUDENT INFORMATION

Name

Address

City State ZIP

Home phone

Cell phone

Email

Date of Birth

Gender

Birthplace

Stonehill ID#

Date Entering Stonehill College

PRIMARY EMERGENCY CONTACT

Contact Name

Home phone

Cell phone

Relationship

SECONDARY EMERGENCY CONTACT

Contact Name

Home phone

Cell phone

Relationship

CONSENT FOR MEDICAL CARE To be signed by students 18 or older, or by their parent/guardian/healthcare proxy agent.

I consent to ALL necessary medical care at Stonehill College or through a medical facility (when required).

Signature of 18-year-old student Date

I give permission for the person named in this Health Report to receive ALL necessary medical care at Stonehill College or through a medical facility (when required).

Printed name of parent/guardian/healthcare proxy agent (if student is younger than 18) Relationship

Signature of parent/guardian/healthcare proxy agent (if student is younger than 18) Date

MEDICAL HISTORY: You are required to provide this information truthfully and accurately.

Student's Last Name ______ First Name ______ Middle Initial ______ Date of Birth ______

FAMILY HISTORY (immediate relatives, which includes parents and siblings)

Name + Relationship	Age	State of Health

Have any of your immediate relatives had any of the following:

Ailment		Relationship
Alcoholism	☐	______
Asthma orAllergies	☐	______
Blood or Bleeding Disorder	☐	______
Cancer	☐	______
Diabetes	☐	______
Heart Disease	☐	______
High Blood Pressure	☐	______
Kidney Disease	☐	______
Mental Illness	☐	______
Seizure Disorder	☐	______
Tuberculosis	☐	______

PERSONAL HISTORY

- ☐ Acne
- ☐ Anemia
- ☐ Appendectomy
- ☐ Arthritis
- ☐ Asthma
- ☐ Blind/visual Impairment
- ☐ Cancer/Malignancy
- ☐ Celiac Disease
- ☐ Concussions
- ☐ Crohn's/Colitis/IBS
- ☐ Deaf/Hearing Impairment
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Emotional/Mental Illness
- ☐ Heart Disease/Problem
- ☐ Hepatitis (Type________)
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Infection/Disease
- ☐ Impaired Mobility/Paralysis
- ☐ Kidney Stone
- ☐ Kidney Disease
- ☐ Learning Disability__________
- ☐ Migraines
- ☐ Mononucleosis
- ☐ Neuromuscular Disease
- ☐ Phlebitis/Deep Vein Clot
- ☐ Pneumothorax
- ☐ Positive TB Test
- ☐ Seizure Disorder
- ☐ Sickle Cell Disease
- ☐ Special Diet/Dietary Restrictions
- ☐ Thyroid Disease
- ☐ TB/Tuberculosis
- ☐ Ulcer/Stomach Problem
- ☐ UTIs (frequent)
- ☐ Other____________________

Explain all positive answers, and please include dates: ______________________________

____

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS: ______________________________

____

MEDICATIONS: Prescription, Over-the-counter, and Herbal ______________________________

____

ALLERGIES: Medications, Food, Insect Venom, Latex ______________________________

____

Please check the box for "yes" or "no" and answer accompanying questions.

☐ Yes ☐ No Do you smoke/vape/use other forms of tobacco or nicotine products? What type and how often? ____________ ____________

☐ Yes ☐ No Do you drink alcohol? How often do you drink? ______________________________

☐ Yes ☐ No Do you use any recreational or non-prescribed drugs? What type and how often?______________________________

☐ Yes ☐ No Have you ever received treatment/counseling for an emotional/mental health issue?______________________________

Dates of treatment: ______________________________

☐ Yes ☐ No Do you exercise regularly? What type and how often? ______________________________

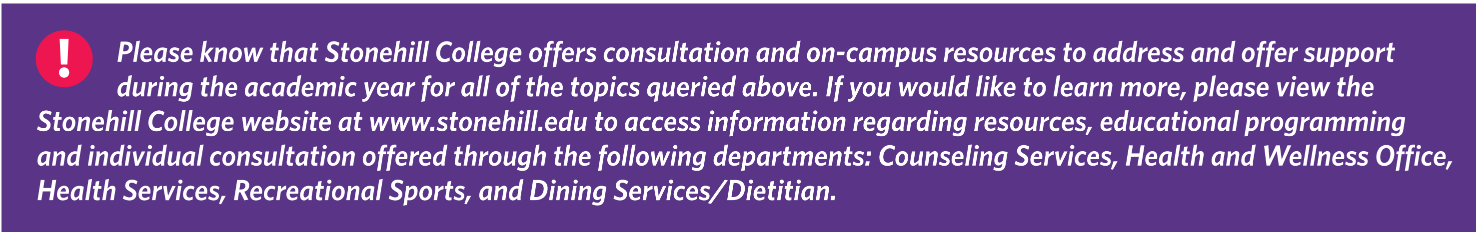
☐ Yes ☐ No Do you follow any special diet or have concerns about your eating patterns? ________ ______________________________

Please provide more detail: ______________________________

Is there anything else that would be helpful for Health Services to know about your medical history that was not reflected above?

____

____



Please know that Stonehill College offers consultation and on-campus resources to address and offer support during the academic year for all of the topics queried above. If you would like to learn more, please view the Stonehill College website at www.stonehill.edu to access information regarding resources, educational programming and individual consultation offered through the following departments: Counseling Services, Health and Wellness Office, Health Services, Recreational Sports, and Dining Services/Dietitian.

IMMUNIZATION RECORD: Please attach a copy of your immunization record from your healthcare provider or have your healthcare provider fill out and sign this form.

Student's Last Name _______ First Name _______ Middle Initial _______ Date of Birth _______

Healthcare Provider Printed Name _______ Signature _______

REQUIRED IMMUNIZATIONS:

Please attach copy of immunization records, that must be signed by a healthcare provider, and any laboratory reports of positive antibody titers.

MMR: MEASLES, MUMPS, RUBELLA VACCINE: 2 doses or proof of immunity.

Dose 1 Date: ______________________

Dose 2 Date: ______________________

OR

Laboratory Tests proving immunity, please attach lab reports.

Measles titer value and date: ______________________

Mumps titer value and date: ______________________

Rubella titer value and date: ______________________

Tdap: TETANUS-DIPHTHERIA ACCELLULAR PERTUSSIS VACCINE: 1 dose is required within the past 10 years.

Dose Date: ______________________

HEPATITIS B VACCINE: 3 doses or proof of immunity.

Dose 1 Date: ______________________

Dose 2 Date: ______________________

Dose 3 Date: ______________________

OR

Laboratory Tests proving immunity, please attach lab reports.

Positive Hepatitis B surface antibody Reactive Date: ______________

Non-reactive Date: ______________

MENINGOCOCCAL MENINGITIS VACCINE: 1 dose MenACWY (formerly MCV4) is required for all full-time students 21 years old or younger. The vaccine must have been received on or after the student's 16th birthday. This vaccine provides coverage against four of the five most common strains of meningitis (A,C,W, and Y).

Menactra ☐ or Menveo ☐ Dose Date: ______________________

☐ Massachusetts Meningitis Waiver Form signed if student declines vaccine after reviewing meningitis information.

VARICELLA VACCINE: 2 doses given at least one month apart, OR documentation of a positive antibody titer, OR documentation of a reliable history of varicella disease (chickenpox) verified by a healthcare provider.

Dose 1 Date: ______________________

Dose 2 Date: ______________________

OR

Laboratory Tests proving immunity, please attach lab reports.

Positive Varicella Titer, please attach lab reports + Date: ______________

History of Disease Date: ______________________

TUBERCULOSIS SCREENING: All students must complete the "Tuberculosis Risk Questionnaire" in this document. If found to be at high risk, a healthcare provider must review and complete the "Medical Evaluation for Latent Tuberculosis," found on page 2 of the "Tuberculosis Risk Questionnaire."

☐ This student has been screened for his or her risk for Tuberculosis and it has been determined that he or she does not require testing.

PPD test result: ☐ Positive ☐ Negative Induration mm. and date: ______________________

Chest x-ray result (in the past six months if positive PPD): ☐ Positive ☐ Negative Date: ______________________

Treatment (include dates): ______________________

RECOMMENDED IMMUNIZATIONS

HEPATITIS A VACCINE:

Dose 1 Date: ______________________

Dose 2 Date: ______________________

HUMAN PAPILLOMAVIRUS VACCINE: Gardasil

Dose 1 Date: ______________________

Dose 2 Date: ______________________

Dose 3 Date: ______________________

MENINGITIS SEROGROUP B VACCINE:

We advise you to receive this important vaccine for full protection against meningitis.

Dose 1 Date: ______________________

Dose 2 Date: ______________________

In accordance with Massachusetts School Immunization Requirements (105 CMR 220.00) Stonehill College requires all full-time undergraduate students to present documentation of immunization to measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, varicella, and meningitis. Requests for medical exemptions may be granted if there is documentation from a healthcare provider stating the reason(s) that these vaccines are contraindicated. Requests for religious exemptions may be granted in accordance with Massachusetts state law governing immunizations. In the event there is an outbreak of any of these vaccine-preventable diseases, students who have been granted exemptions will be required to leave campus and will return when the period of communicability has passed.

CLINICAN'S MEDICAL REPORT AND RECOMMENDATIONS

Although a physical exam is not required prior to entering college, an annual physical exam is strongly recommended. In lieu of filling out this form, you can also submit clinician documentation of your most recent physical, if signed by your clinician.

STUDENT INFORMATION

Student's Last Name First Name Middle Initial Date of Birth

Height Weight Blood Pressure Pulse

CURRENT AND CHRONIC PROBLEMS

ALL CURRENT MEDICATIONS

ALL CURRENT ALLERGIES

DIETARY REQUIREMENTS OR RESTRICTIONS

PHYSICAL LIMITATIONS OR RESTRICTIONS

ADDITIONAL COMMENTS

PHYSICIAN INFORMATION

Name (First, Last, MI) Clinician Signature

Title Today's Date

Phone Fax Email Website

Mail completed form by June 28 to: Stonehill College Health Services, 320 Washington Street, Easton, MA 02357-5710