



Framingham

STATE COLLEGE

Student Health Services HEALTH AND WELLNESS CENTER

Phone: (508) 626-4900

Foster Hall, Framingham, MA 01701-9101

www.framingham.edu/healthservices/

Fax: (508) 626-4024

NAME: _____ Date of Birth: _____
Last First MI Month Day Year

Permanent Address: _____
Street

_____ Birthplace: _____
City State Zip Country

Home Phone: () Cell Phone: () Male Female

Please check all appropriate boxes: Commuter Campus Resident Freshman
 Graduate Student Transfer Returning Student
Years attended FSC _____
ID no. _____

PARENT/GUARDIAN/or other emergency contact:

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

Home Phone: () Business Phone: () Fax: ()

ALTERNATE EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

Home Phone: () Business Phone: ()

PRIMARY HEALTH CARE PROVIDER Name and Phone no.: _____

CONSENT FOR MEDICAL CARE	
<i>I, the undersigned, hereby authorize the Medical Staff of Framingham State College to provide care in the Office of Health Services and also grant permission for emergency treatment to be rendered at local medical facilities.</i>	
Student Name: _____	Date: _____
Student Signature: _____	
Parent Signature (if student under 18): _____	

Name: _____

IMMUNIZATIONS

(to be completed by health care provider only)

Massachusetts Law Requires Proof of the Following Immunizations:

MMR (Measles, Mumps, Rubella) 2 doses required	Month	Year
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____	_____
<input type="checkbox"/> Dose 2 (Given at least 1 month after Dose 1)	_____	_____
OR		
<input type="checkbox"/> Serology results	_____	_____

Diphtheria/Tetanus		
<input type="checkbox"/> Booster within last ten years	_____	_____

Hepatitis B			
<input type="checkbox"/> Primary Series	#1 _____	#2 _____	#3 _____
If unable to document dates, titer required			(COMPLETED)
<input type="checkbox"/> Hepatitis B Serology Results _____	_____	_____	_____

Meningococcal Vaccine		
<input type="checkbox"/> Received Vaccine	<input type="checkbox"/> Menactra	<input type="checkbox"/> Menomune
<input type="checkbox"/> Signed Waiver	_____	_____

PPD required if any of the following questions are answered yes:		
<input type="checkbox"/> Born, lived or travelled in Africa, Asia except Japan, Central/South America, Mexico, Eastern Europe, Caribbean, or Middle East.		
<input type="checkbox"/> Have a household member with HIV or who uses intravenous drugs.		
<input type="checkbox"/> Worked in a high-risk congregate setting such as prison.		
<input type="checkbox"/> Had close contact with anyone who was sick with TB.		
PPD / Results		
<input type="checkbox"/> Chest X-ray (if positive PPD) Results _____	_____	_____
<input type="checkbox"/> Completed course of INH <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

Signature of Health Care Provider

Address

HEALTH INSURANCE INFORMATION

Health Insurance Policy Name: _____

Policy #: _____ Subscriber: _____

Name: _____

MEDICAL HISTORY

(To be completed by student)

FAMILY HISTORY

	Age	State of Health	Age of Death	Cause of Death	Have any of your immediate relatives had any of the following:		Relationship
					Yes		
Father					Alcohol/Substance Abuse		
Mother					Asthma		
Siblings					Cancer		
					Diabetes		
					Heart Disease/High Blood Pressure		
Spouse					Mental Illness/Depression		
Children					Sudden Death Before Age 50		
					Other		

PERSONAL HISTORY Do you have now or have you ever had (check all that apply):

- | | | | |
|-------------------------------------------------------------|-------------------------------------------------------|----------------------------------------------------------|-------------------------------------------------------------|
| 1. <input type="checkbox"/> ADD/ADHD | 13. <input type="checkbox"/> Deaf/hearing impairment | 24. <input type="checkbox"/> Impaired mobility/paralysis | 35. <input type="checkbox"/> Serious illness |
| 2. <input type="checkbox"/> Anemia | 14. <input type="checkbox"/> Depression | 25. <input type="checkbox"/> Kidney disease/stones | 36. <input type="checkbox"/> Sexually transmitted infection |
| 3. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 15. <input type="checkbox"/> Diabetes | 26. <input type="checkbox"/> Learning disability | 37. <input type="checkbox"/> Sickle cell disease |
| 4. <input type="checkbox"/> Anxiety/Panic attacks | 16. <input type="checkbox"/> Emotional/mental illness | 27. <input type="checkbox"/> Loss of consciousness | 38. <input type="checkbox"/> Skin problems |
| 5. <input type="checkbox"/> Appendectomy | 17. <input type="checkbox"/> Fracture/sprain | 28. <input type="checkbox"/> Migraines/chronic headaches | 39. <input type="checkbox"/> Sleep disturbance |
| 6. <input type="checkbox"/> Arthritis | 18. <input type="checkbox"/> Heart disease/problem | 29. <input type="checkbox"/> Mononucleosis | 40. <input type="checkbox"/> Thyroid disease |
| 7. <input type="checkbox"/> Asthma | 19. <input type="checkbox"/> Hepatitis (Type _____) | 30. <input type="checkbox"/> Obesity | 41. <input type="checkbox"/> Positive TB Test |
| 8. <input type="checkbox"/> Back Problems | 20. <input type="checkbox"/> Hernia | 31. <input type="checkbox"/> Paralysis or Disability | 42. <input type="checkbox"/> Tuberculosis disease |
| 9. <input type="checkbox"/> Blind/visual impairment | 21. <input type="checkbox"/> High blood pressure | 32. <input type="checkbox"/> Phlebitis/deep vein clot | 43. <input type="checkbox"/> Ulcer/stomach problem |
| 10. <input type="checkbox"/> Cancer/malignancy | 22. <input type="checkbox"/> High cholesterol | 33. <input type="checkbox"/> Seizure disorder | 44. <input type="checkbox"/> UTIs (frequent/recurrent) |
| 11. <input type="checkbox"/> Chickenpox | 23. <input type="checkbox"/> HIV infection/disease | 34. <input type="checkbox"/> Serious accident | 45. <input type="checkbox"/> Other _____ |
| 12. <input type="checkbox"/> Crohn's/Ulcerative Colitis/IBS | | | |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates): _____

LIST ANY HEALTH PROBLEMS NOT ALREADY NOTED:

INPATIENT HOSPITALIZATIONS: Please list all medical/psychiatric hospitalizations, dates, diagnoses, and surgeries:

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medications, antidepressants, herbal supplements etc.:

ALLERGIES: None known Yes

(If yes, please specify, including medications, insect, venom, foods, etc.): _____ Type of reaction: _____

1. Do you smoke cigarettes? Yes No Number per day? _____ For how many years? _____
2. Do you drink alcohol? Yes No How often? _____ When you drink, how many do you usually have? _____
3. Do you now or have you ever used recreational drugs? Yes No Which ones? _____ How often? _____
4. How often do you exercise? Never Daily 3-5 times/week Weekly What type of exercise? _____
5. When riding in a car, what % of the time do you wear a seatbelt? _____%
6. Is there anything else we need to know about your health? _____

