



Student Health Services
FRAMINGHAM STATE COLLEGE
HEALTH AND WELLNESS CENTER

Phone: (508) 626-4900

Foster Hall, Framingham, MA 01701-9101
www.framingham.edu/healthservices/

Fax: (508) 626-4024

NAME: _____
Last First MI

Date of Birth: _____
Month Day Year

Permanent Address: _____
Street

Soc. Sec. no.: _____

_____ City State Zip Country

Birthplace: _____

Home Phone: _____ () Cell Phone: _____ ()

E-mail: _____

Please check all appropriate boxes:

- Commuter Campus Resident
 Graduate Student Transfer

- Freshman
 Returning Student
Years attended FSC _____
ID no. _____

PARENT/GUARDIAN/NEXT-OF-KIN INFORMATION (*for contact in case of emergency*):

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 CARE PROVIDER Name and Phone no.: _____

CONSENT FOR MEDICAL CARE

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.

Student Name: _____ Date: _____

Student Signature: _____

Parent Signature (*if student under 18*): _____

IMMUNIZATIONS

(to be completed by health care provider only)

Name: _____

Required

	<i>Month</i>	<i>Year</i>
<u>MMR (Measles, Mumps, Rubella)</u> 2 doses required <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		
<u>Measles</u> (If given instead of MMR) 2 doses required <input type="checkbox"/> Dose 1 (Immunized on or after first birthday) <input type="checkbox"/> Dose 2 (One month after dose 1) If unable to document 2 Measles Immunization dates, <i>must provide</i> : <input type="checkbox"/> Measles Serology Results _____	_____	_____
<u>Mumps</u> (If given instead of MMR) 1 dose required <input type="checkbox"/> Dose 1 (Immunized on or after first birthday) If unable to document Mumps Immunization date, <i>must provide</i> : <input type="checkbox"/> Mumps Serology Results _____	_____	_____
<u>Rubella</u> (If given instead of MMR) 1 dose required <input type="checkbox"/> Dose 1 (Immunized on or after first birthday) If unable to document Mumps Immunization date, <i>must provide</i> : <input type="checkbox"/> Rubella Serology Results _____	_____	_____

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

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

<u>Meningococcal Vaccine</u>		
<input type="checkbox"/> Received Vaccine	_____	_____
<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.		
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

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:	
					Yes	Relationship
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: _____

FOR WOMEN ONLY, CHECK ALL THAT APPLY:

Date of last **PAP smear**: _____ Result: _____ Have you ever had an abnormal **PAP smear**? _____ Colposcopy? _____ Date: _____

<input type="checkbox"/> Irregular periods/no periods	<input type="checkbox"/> Pelvic inflammatory disease (PID)	<input type="checkbox"/> Other sexually transmitted infection (STI/STD) _____
<input type="checkbox"/> Polycystic Ovary Syndrome (PCOS)	<input type="checkbox"/> Genital herpes (HSV)	<input type="checkbox"/> Use CONTRACEPTION <input type="checkbox"/> BCP (Pill) <input type="checkbox"/> Other _____
<input type="checkbox"/> Breast lumps/fibrocystic disease	<input type="checkbox"/> Genital warts (HPV)	<input type="checkbox"/> Pregnancy (live births) # _____ <input type="checkbox"/> Abortion/Miscarriage # _____

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. Are you concerned about your own, a friend's or family member's drinking or drug use? Yes No
5. How often do you exercise? Never Daily 3-5 times/week Weekly What type of exercise? _____
6. When riding in a car, what % of the time do you wear a seatbelt? _____%
7. Do you follow any diets? Yes No What kind? _____ Are you concerned with your eating habits? Yes No
8. How much do you weigh? _____ lbs. How tall are you? _____ What is your **desired** weight? _____ lbs.
9. Do you often have a feeling of being anxious, overwhelmed or depressed? Yes No
10. Have you ever received treatment or counseling for an emotional problem? Yes No
11. Are you currently in counseling/therapy? Yes No Dates of treatment: _____
12. Is there anything else we need to know about your health? _____

Please use additional pages if needed to answer questions completely.

PHYSICAL EXAMINATION

A PHYSICAL EXAMINATION WITHIN THE PAST YEAR IS REQUIRED.

TO THE HEALTH CARE PROVIDER: Please review the student's history and complete the physical exam form. The information supplied will be used as a background for providing health care.

Student's Name: _____ **Date of Exam:** _____

ABNORMALITIES:

No.	System	Yes	No	List number and describe abnormality
1.	Skin			
2.	Eyes			
3.	Ears			
4.	Nose, throat, teeth			
5.	Neck, thyroid			
6.	Lymphatics			
7.	Chest, lungs			
8.	Breasts			
9.	Heart			
10.	Abdomen, liver, kidneys, spleen			
11.	Hernia			
12.	Genitalia			
13.	Pelvic (if indicated)			
14.	Back and spine			
15.	Extremities, joints			
16.	Neurological			
17.	Psychological			

Lab work recommended: Hgb/Hct: _____ Cholesterol: _____ Urine: Glucose: _____ Protein: _____ Micro: _____

Height: _____ **Weight:** _____ **BP:** _____ **Pulse:** _____

CURRENT MAJOR AND CHRONIC PROBLEMS:

ACUTE OR MINOR PROBLEMS:

IF THE STUDENT IS UNDER CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

Hospitalizations: _____ Surgeries: _____

Reason and Date: _____ Type and Date: _____

I have known applicant for _____ years.

ALLERGIES (medications, foods, insect, venom): _____

Type of reaction: _____

CURRENT MEDICATIONS (include vitamins, OTCs, contraceptives): _____

POTENTIAL ATHLETES: Students are NOT eligible to practice or participate in intercollegiate sports until this form has been completed and submitted to Health Services.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY: Collision Contact Non-contact

Health Care Provider (please print): _____

Address: _____

Phone: (_____) _____ FAX: (_____) _____

Provider's Signature: _____