



ADMISSION HEALTH FORM

Name: _____ Date of birth: _____ FSU ID: _____

IMMUNIZATIONS

(to be completed by health care provider only)

Massachusetts Law Requires Proof of the Following Immunizations:

1. Please have your health care provider complete this form or obtain their record of your completed immunizations.
2. Upload the completed immunization and physical exam forms (signed by your health care provider) to the Patient Portal:
<http://framingham.medicatconnect.com>

MMR (Measles, Mumps, Rubella) 2 doses required	Date
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____
<input type="checkbox"/> Dose 2 (Given at least 4 weeks after Dose 1)	_____
OR	
<input type="checkbox"/> Serology results (TITERS) Measles _____ Mumps _____ Rubella _____	
(SUBMIT COPY OF LAB REPORT)	

Tdap (Tetanus, Diphtheria, Pertussis)	Date
<input type="checkbox"/> Booster within last ten years	_____

Hepatitis B			
<input type="checkbox"/> Primary Series #1 _____ #2 _____ #3 _____			
OR			(COMPLETED)
<input type="checkbox"/> Hepatitis B Serology (TITER) Results _____			
(SUBMIT COPY OF LAB REPORT)			

Varicella Vaccine (Chicken Pox)	Date
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____
<input type="checkbox"/> Dose 2 (Given at least 4 weeks after Dose 1)	_____
OR	
<input type="checkbox"/> Serology (TITER) results	_____
(SUBMIT COPY OF LAB REPORT)	
OR	
<input type="checkbox"/> Chickenpox disease (self report with review by healthcare provider)	_____

Meningococcal Vaccines: (Applies to newly enrolled fulltime residential students ONLY)	Date
<input type="checkbox"/> Received Vaccine (Menactra, Menveo, Menomune, MCV4)	_____
OR	
<input type="checkbox"/> Signed Waiver (enclosed)	_____

Signature of Health Care Provider

Address

Name: _____ Date of birth: _____ FSU ID: _____

PHYSICAL EXAMINATION

A PHYSICAL EXAMINATION WITHIN THE PAST 18 MONTHS IS REQUIRED.

Date of Exam: _____

ABNORMALITIES:

No.	System	Yes	No	List number and describe abnormality
1.	Skin			
2.	HEENT			
3.	Neck, thyroid			
4.	Chest, lungs			
5.	Breasts			
6.	Heart			
7.	Abdomen			
8.	Genitalia			
9.	Musculoskeletal			
10.	Neurological			
11.	Psychological			
12.	Neurological			

Height: _____ Weight: _____ BMI: _____ Pulse: _____ BP: _____

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, varsity or club sports until this form has been completed and submitted to the Health Center.

RECOMMENDATIONS

FOR PHYSICAL ACTIVITY:

* CHECK ONE *

- Collision: Hockey, Football, Rugby, Cheerleading, Men's Lacrosse
- Contact: Women's Lacrosse, Baseball, Basketball, Soccer, Softball, Baseball, Field Hockey, Volleyball
- Non-Contact: Cross Country

Health Care Provider (please print): _____

Address: _____

Phone: () _____ FAX: () _____

Provider's Signature: _____ Date of Exam: _____

Framingham State University

Tuberculosis assessment/documentation form

****STUDENT: this form is only required for those that answered YES to online TB screening questionnaire****

Student Name _____ DOB: _____

TO THE PROVIDER: This student has previously answered **yes** to one of the following questions and is required to have TB testing or documentation as outlined below for admission into Framingham State University.

PPD is required **within 6 months** of the beginning of the semester if any of the following are applicable.

- Were you born in Africa, Asia (except Japan), Central/South America, Mexico, Eastern Europe, Caribbean or Middle East?
- Have you ever had a positive TB test or been diagnosed with Tuberculosis?
- Have you ever had close contact with persons known or suspected to have active TB disease?

***Testing must have been performed within 6 months of semester start date.**

- Tuberculin skin test (TST) Date: _____ Results: _____
or
- T-Spot Date: _____ Results: _____
or
- QuantiFERON-TB Gold Date: _____ Results: _____

Chest x-ray and documentation are required if the following is applicable.

- Student has had a positive TB test or has been diagnosed with TB in the past.
 - Positive PPD/blood test Date: _____
 - Chest X-Ray Date: _____ Results: Positive Negative
 - Completed course of INH yes No

Provider Signature: _____ Date: _____