Framingham State University

HEALTH CENTER
Foster Hall, Framingham, MA 01701-9101
http://framingham.medicatconnect.com
P: (508) 626-4900

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: **framingham.medicatconnect.com**

MMR (Measles, Mumps, Rubella) **2 doses required** **Date**

☐ Dose 1 (Immunized on or after first birthday) _____
☐ Dose 2 (Given at least 4 weeks after Dose 1) _____
OR
☐ Serology results (TITERS) Measles_____ Mumps _____ Rubella _____
(SUBMIT COPY OF LAB REPORT)

Tdap (Tetanus, Diptheria, Pertussis) **Date**

☐ Booster within last ten years _____

Hepatitis B

☐ Primary Series #1_____ #2_____ #3_____
(COMPLETED)
OR
☐ Hepatitis B Serology (TITER) Results_____
(SUBMIT COPY OF LAB REPORT)

Varicella Vaccine (Chicken Pox) **Date**

☐ Dose 1 (Immunized on or after first birthday) _____
☐ Dose 2 (Given at least 4 weeks after Dose 1) _____
OR
☐ Serology (TITER) results _____
(SUBMIT COPY OF LAB REPORT)
OR
☐ Chickenpox disease (self report with review by healthcare provider) _____

Meningococcal Vaccine: **(Applies to newly enrolled fulltime residential students ONLY)** **Date**

☐ Received Vaccine (Menactra, Menveo, Menomune, MCV4) _____
OR
☐ Signed Waiver (enclosed) _____

Covid-19 vaccine :

Date	**Date**	**Date**
Pfizer Dose 1 _____	Moderna Dose 1 _____	Johnson & Johnson Dose 1 _____
Pfizer Dose 2 _____	Moderna Dose 2 _____	Johnson & Johnson Booster _____
Pfizer Booster _____	Moderna Booster _____	

_ _____ _____
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: Please complete this form if you 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:_____

Revised April 2022