CONNECTICUT COLLEGE

Student Health Form

DIRECTIONS: Connecticut state law and the policy of Connecticut College mandate that a completed health form be on file in order for students to attend classes. The information you provide will be kept confidential. If you will be using your family's health insurance plan for primary or secondary coverage, please send a copy of the card with this form. **When completed, mail this form along with the Athletic Health Screening Form in envelope #2 to Student Health Services, Box HLTH CTR, Connecticut College, 270 Mohegan Ave., New London, CT 06320-4196 by Jan. 16, 2012.**

ADMISSION STATUS – Class year: ☐ Freshman ☐ Transfer ☐ Master's candidate ☐ Return to college ☐ National Theater Institute ☐ Other:

Personal Information

Last name: First name: MI:

☐ Male ☐ Female Birth date (mm/dd/yy): Citizenship:

Permanent address: City: State: Zip code:

Home phone: Cell phone:

Emergency Contacts

In the event of serious illness or injury, parents or guardians will be notified at the discretion of the staff.

Parent/guardian name: Home #: Work #: Cell #:

Parent/guardian name: Home #: Work #: Cell #:

Please provide an additional contact if parents/guardians are unavailable.

Name: Relationship to you:

Address:

Home phone: Work phone: Cell phone:

Permission for Medical Care

I authorize Connecticut College Student Health Services to provide medical treatment and services, or when circumstances require immediate action to proceed according to standard medical practices.

Student signature: Date:

Parent/guardian signature (if student is under 18 years of age): Date:

Family's Health History

Are you adopted? ☐ Yes ☐ No

Relative	Age	General health	Past or present serious illness	If deceased, note cause of death	Age at death
Father/mother					
Father/mother					
Brother/sister					
Brother/sister					
Brother/sister					
Brother/sister					

Please attach additional pages if needed.

Personal Health History

Do you have or have you ever had any of the following?

1. Allergic reaction(s) to drugs or food ☐ Yes ☐ No
2. Seasonal allergies ☐ Yes ☐ No
3. Cardiac condition/heart murmur ☐ Yes ☐ No
4. Hospitalizations ☐ Yes ☐ No
5. Operations or serious injuries ☐ Yes ☐ No
6. Asthma ☐ Yes ☐ No
7. Mononucleosis ☐ Yes ☐ No
8. Tuberculosis ☐ Yes ☐ No
9. Chronic Fatigue Syndrome ☐ Yes ☐ No
10. Jaundice, hepatitis ☐ Yes ☐ No
11. Malaria or other tropical disease ☐ Yes ☐ No
12. Seizure disorder ☐ Yes ☐ No
13. Skin disorder ☐ Yes ☐ No
14. Migraine, headaches ☐ Yes ☐ No
15. Severe head injury, concussion ☐ Yes ☐ No
16. Vision or hearing impairment ☐ Yes ☐ No
17. Serious disease of eyes or ears ☐ Yes ☐ No
18. Persistent dental problems ☐ Yes ☐ No
19. Persistent cough ☐ Yes ☐ No
20. High blood pressure ☐ Yes ☐ No
21. Intestinal bleeding or chronic abdominal pain ☐ Yes ☐ No
22. Lyme disease ☐ Yes ☐ No
23. Kidney disease or bladder problems ☐ Yes ☐ No
24. Diabetes ☐ Yes ☐ No
25. Sickle cell trait ☐ Yes ☐ No
26. Thyroid or other endocrine disorder ☐ Yes ☐ No
27. Anemia, other blood disorder ☐ Yes ☐ No
28. Muscle, bone or joint disorder ☐ Yes ☐ No
29. Cancer or other tumors ☐ Yes ☐ No
30. Smoker ☐ Yes ☐ No
31. High cholesterol ☐ Yes ☐ No
32. Anxiety or depression ☐ Yes ☐ No
33. ADD/ADHD ☐ Yes ☐ No
34. Sleep disorder ☐ Yes ☐ No
35. Obsessive compulsive disorder ☐ Yes ☐ No
36. Suicide attempts ☐ Yes ☐ No
37. Eating disorder ☐ Yes ☐ No
38. An abusive/controlling relationship ☐ Yes ☐ No
39. Alcohol/drug problem ☐ Yes ☐ No
40. HIV/AIDS ☐ Yes ☐ No

Men Only

41. An undescended testicle, testicular mass, lump ☐ Yes ☐ No

Women Only

42. Problems with menstrual periods ☐ Yes ☐ No
43. Abnormal pap ☐ Yes ☐ No

44. Have you participated in sports in the past two years? ☐ Yes ☐ No
45. Do you plan to participate in sports while in college? ☐ Yes ☐ No
46. Have you ever been disqualified from a sport due to illness or injury? ☐ Yes ☐ No
47. Are there any other aspects of your health that may require special medical arrangements while attending Connecticut College? ☐ Yes ☐ No

If you answered "yes" to anything above, please explain here:

Medications taken regularly (include allergy injections, birth control, antidepressants, pain control, vitamins, etc.):

Name	Dosage	Frequency	Reason

Name: Date of Birth:

Immunization Exemption

Students are exempt from the mandatory immunization requirements (measles, rubella, varicella, meningitis) if there is a medical contraindication or if religious belief prohibits immunizations. A signed statement is required. Students born prior to Jan. 1, 1957, are exempt from measles and rubella requirements. Exemption for either medical or religious reasons subjects the individual to exclusion from campus in the event of an outbreak of a disease for which immunizations are required.

☐ I requested an exemption for religious reasons ☐ I requested an exemption for medical reasons

Signature of student (or parent/guardian if student is under age 18):

State of Connecticut and Connecticut College Required Vaccines

Instructions to the health care provider: Review the family and personal history, then complete the immunization record and the following page. This person has been accepted at Connecticut College. The information will not affect his/her status and will be kept confidential. It will be used to provide care.

MMR Dose #1 ☐ (mm/dd/yy): Must be on or after 1st birthday and after Jan. 1, 1969

MMR Dose #2 ☐ (mm/dd/yy): Must be at least 30 days after first immunization and after Jan. 1, 1980

Titer test results (if vaccination date unavailable) ☐ Pos ☐ Neg | Date of titer:

MENINGOCOCCAL (check vaccine type ☐ Menactra ☐ Menomune) (mm/dd/yy): Must be within five years of matriculation

VARICELLA | Date of dose #1: Date of dose #2: | Or disease date: | Or titer date: Result: ☐ Pos ☐ Neg

Other Vaccinations

TETANUS ☐ or **TDAP** ☐ Date:

HEPATITIS A Date of dose #1: Date of dose #2:

HEPATITIS B Date of dose #1: Date of dose #2: Date of dose #3: Hepatitis titer date: Result: ☐ Pos ☐ Neg

HPV VACCINATION Date of dose #1: Date of dose #2: Date of dose #3:

POLIO (date of completed series): | **TYPHOID** Date: | **YELLOW FEVER** Date:

Tuberculosis Screening (required)

Risk questionnaire (to be answered by student)

A. Have you ever had a positive tuberculosis skin test in the past? ☐ Yes ☐ No | If yes see Chest X-ray section on reverse side
B. To the best of your knowledge have you ever had close contact with anyone who was sick with TB? ☐ Yes ☐ No
C. Were you born in one of the countries listed below? ☐ Yes ☐ No | If yes circle country

D. Have you traveled or lived for more than one month in one or more of the countries listed below? ☐ Yes ☐ No | If yes circle country

Afghanistan, Algeria, Angola, Argentina, Armenia, Azerbaijan, Bahrain, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Cape Verde, Central African Republic, Chad, China, Colombia, Comoros, Congo, Cook Islands, Côte d'Ivoire, Croatia, Democratic People's Republic of Korea, Democratic Republic of Congo, Djibouti, Dominican Rep., Ecuador, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, French Polynesia, Gabon, Gambia, Georgia, Ghana, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Japan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao PDR, Latvia, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mauritius, Micronesia (Federated States of), Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nicaragua, Niger, Nigeria, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Macedonia, Republic of Moldova, Romania, Russian Federation, Rwanda, Saint Vincent and the Grenadines, São Tomé and Príncipe, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, Sri Lanka, Sudan, Suriname, Swaziland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Vietnam, Yemen, Zambia, Zimbabwe

If you answer yes to questions B-D, Connecticut College requires that a health care provider complete the tuberculosis testing evaluation on the reverse side within one year prior to the start of classes. Prior BCG does not exempt patient from this requirement. If you answer no to all questions, no further action is required.

International students from the countries listed above will be screened at Connecticut College. TB screening tests are not accepted from other countries because testing methods differ.

Health care provider's signature: Date:

Name: Date of Birth:

Tuberculin Skin Test

☐ Indicated ☐ Not indicated

Note: Use 5TU Mantoux test only. Multiple puncture test such as Tine is not accepted.

Date planted: Date read: Interpretation: ☐ Pos ☐ Neg mm of induration (if no induration, mark '0')

Quantiferon Blood Test

Date: Result: ☐ Pos ☐ Neg

Chest X-ray (required if answered Yes to question A)

Date: ☐ Normal ☐ Abnormal

Medication Treatment

Treatment completion date: Dose and frequency:

Physical Examination

Physical exams must be done within one year prior to the start of classes. Connecticut College does not accept physical exams performed by a family member.

Physical examination date: | Blood pressure: Pulse:

Height: Weight: BMI: Women only: HGB/HCT:

	Normal	Abnormal	Comments
Allergies (list)	☐	☐	
Skin	☐	☐	
HEENT	☐	☐	
Neck	☐	☐	
Cardiovascular	☐	☐	
Lungs	☐	☐	
Breasts	☐	☐	
Abdominal	☐	☐	
Musculo-skeletal	☐	☐	
Genitourinary	☐	☐	
Neurological	☐	☐	
Psychological	☐	☐	

Additional comments and recommendations:

Having examined this applicant and reviewed his or her past medical history, I consider that ____ is fit to attend Connecticut College. **I have received permission from this student and would be willing, if indicated, to discuss issues pertaining to his/her health status with the professional staff of Student Health Services and will furnish additional pertinent medical records upon request.**

Health care provider's name: Phone: Fax:

Address:

Signature: Date:

Athletic Health Screening Form

All students must complete this form, even if athletic participation is not expected — many change their minds. The student should fill out this page and then give the form to his/her health care provider to **complete** and **sign** at the end. **NCAA rules require all physicals be dated within six months of the first sports participation. Connecticut College does not accept physical exams performed by a family member.** This form will be sent to an athletic trainer for review. Be sure your name is legible.

Last name: First name: MI:

Class year: Any sport(s) you might play:

Medical History

Sickle cell disease or trait: ☐ Yes ☐ No

Have you had the following in the past five years? If so, please note month and year.

	Yes	No	Date (mm/yy)		Yes	No	Date (mm/yy)
Anemia	☐	☐		Heart murmur*	☐	☐	
Mono	☐	☐		Heart disease	☐	☐	
Asthma	☐	☐		Fainting**	☐	☐	
Diabetes	☐	☐		High blood pressure	☐	☐	
Eating disorder	☐	☐		Irregular pulse	☐	☐	
Kidney disease	☐	☐		Seizures	☐	☐	

Have you had an acute illness, surgery or hospitalization in the past year? Please explain:

*Do you still have this heart murmur? ☐ Yes ☐ No (if yes, make sure your health care provider fills in the information on the reverse side)

**Was your fainting related to exercise? Please explain:

Previous Injury History

If you have injured any of the following joints within the last five years, severely enough to limit play for more than five days, please describe (include strains, sprains, fractures, dislocations, surgery, etc.):

☐ Ankle: ☐ Knee:

☐ Back: ☐ Shoulder:

☐ Elbow: ☐ Neck:

CONCUSSION? ☐ Yes ☐ No | **DATE(S):**

Have you ever been told to stop playing your sport permanently? ☐ Yes ☐ No | If yes, please explain:

Any other injury or chronic problem we should know about? ☐ Yes ☐ No | If yes, please explain:

Name: Date of Birth:

Health Care Provider's Evaluation

Please note: the cardiovascular exam is required by the NCAA. Please answer each question or the student's athletic participation will be delayed.

1. **DATE OF EXAM** (mm/dd/yyyy): 2. SITTING BRACHIAL BLOOD PRESSURE: /

3. **PRECORDIAL AUSCULTATION** (note any heart murmurs, especially those consistent with dynamic left ventricular outflow obstruction):

A. SUPINE: ☐ Normal/no murmur heard | If murmur heard, please describe:

B. STANDING: ☐ Normal/no murmur heard | If murmur heard, please describe:

4. BILATERAL FEMORAL ARTERY PULSES (to exclude coarctation of the aorta):

☐ Normal | If not, please describe:

5. Any stigmata of Marfan syndrome? ☐ Yes ☐ No | If yes, please describe:

6. Please note if there are any problems that need follow-up:

Health Care Provider's Clearance:

Please note: one of the following must be checked or the student's athletic participation will be delayed.

☐ I recommend this student be allowed to participate in any varsity, club or intramural athletics without limits.
☐ I recommend this student be allowed to participate in any varsity, club or intramural athletics with the following limitations:

☐ I recommend this student *not* be allowed to participate in any varsity, club or intramural athletics.

Please print legibly or use a stamp and sign:

Health care provider's name: Signature:

Address:

Phone number: