Health Services

TO BE FILLED OUT BY THE STUDENT.
Information will be used to provide better health care for you while at MCLA, and has no bearing upon the admissions process.

Please Print: Male: ❑ Female: ❑ Transgender: ❑

Name: ______________________ (Last / First / M.I.) Date of Birth: __________ S.S. #: __________

Home Address: ______________________ (Street / City / State / Zip)

Home Phone #: __________ Student Cell Phone #: __________

Emergency, Contact __________ Relationship __________

Home Phone: __________ Business Phone; __________

For Students under 18 years old

Emergency: Permission is hereby granted for the emergency use of anesthesia and emergency medical treatment for my minor.

Signature: (Parent or Legal Guardian) __________

Drug allergies: ❑ Yes ❑ No

If yes, list drug and reaction: __________

Other Allergies: e.g., insects, food: __________

PERSONAL MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Anxiety/Panic Attacks			Eye Problems			Substance/Alcohol Abuse		
Anemia			GERD			Surgery		
Asthma/Other Lung Disease			Head Injury/Concussion			Appendectomy		
Attention Deficit Disorder			Headaches (Recurrent)			Tonsillectomy		
Back Injury/ Problem			Hearing Deficit			Other:		
Birth Control			Heart disease					
Bleeding Disorders			Hepatitis			Thyroid Disease		
Blood Transfusion			High Blood Pressure			Tuberculosis		
Chicken Pox			Kidney Problem			Ulcer/Gastritis		
Depression			Menstrual Disorder			Urinary Tract Infection		
Diabetes			Mononucleosis			Other significant medical problems (specify):		
Disease/Injury of Joints/Bones			Seizures					
Ear, Nose, Throat Problems			Smoker					
Eating Disorders			Strep Throat (Frequent)					

Mental health history: __________

Important family history e.g., heart disease, diabetes, cancer, etc.: __________

List any regularly taken medications and the condition for which they are prescribed: __________

__________ Student's Signature

__________ Health Care Provider's Signature (acknowledging review)

Notice of privacy practice received on: Date __________ Student Signature __________

Name: __________ **Date of birth** __________

REQUIRED FOR COLLEGE ENTRY

TO BE FILLED OUT BY THE HEALTH CARE PROVIDER:

Initial series

Td __________ (Month/Year (within 10 yrs.))

MMR #1 __________ (Month/Day/Year (must be 12 months of age))

MMR #2 __________

OR

2 Measles __________ (Month/Day/Year)

Mumps __________ (Month/Year)

Rubella __________ (Month/Year)

Hepatitis B Series:

#1 __________

#2 __________

#3 __________

* Meningococcal Vaccine __________

* Students may not attend classes without proof of Meningococcal Vaccine within the past 5 years or a signed waiver. If you choose not to be vaccinated against meningitis, read the enclosed information sign the waiver and return it to this office.

Signature of Health Care Provider or Nurse __________ Tel.# __________

Varicella or history of disease) __________

Health Care Provider: Please review the information on Side 1 and acknowledge with your signature at the bottom. Complete this side, commenting on positive responses. Please describe any significant abnormalities.

Hgt. ______ Wgt. ______ B.P. ______

	nl	abnl	Comments
Head, ears, nose, throat			
Respiratory			
Cardiovascular			
Hernia			
Eyes, other than acuity			
Gastrointestinal			
Genitourinary			
Musculoskeletal			
Metabolic endocrine			
Neuropsychiatric			
Skin			

Any allergies to medications/foods. etc.? ❑ No ❑ Yes If yes, list substance and reaction __________

Is patient on medications at this time? __________

Is the student now under treatment for any medical or emotional condition: ❑ No ❑ Yes Explain: __________

Are there any contraindications to full participation in intercollegiate athletics/intramurals/other sports activities?

❑ No ❑ *Yes

*Limitations (please explain) __________

Health Care Provider's signature __________ Tel. # __________

Please print or type Provider's name & address __________

Date __________

Please note: Registration at MCLA is not valid unless fully completed form (both sides) is received by Health Services.

Mail to: Director of Health Services, MCLA, 375 Church St., North Adams, MA 01247-4100 • FAX: 413-662-5572