A MESSAGE FROM MCLA HEALTH SERVICES

Welcome to MCLA! The Health Services staff would like to congratulate you on your acceptance and wish you a rewarding and successful academic year.

As you are now part of the MCLA family, it is our goal to provide you with the best care possible, so we are asking you to review and sign the Health Information Use and Disclosure form that is included in this packet for download. This release form will allow MCLA Health Services the ability to access your hospital records should you require emergency care from one of the local hospitals. This release complies with HIPPA guidelines, while allowing us to provide you with the highest possible care and assist you in any follow-up care required. Please note this information is maintained in the strictest confidence and will only be used as needed.

All new students taking 9 or more credits and who are under 30 years of age are required to complete Health Services forms and requirements before attending classes. If you are a Health Science major, you are required to complete Health Services forms and requirements regardless of age or credits. The required Health Form is enclosed and is also conveniently located on the MCLA Health Services website. In addition to the Health Form, please have your primary care provider attach a copy of your most recent physical examination. All students must also complete and sign the TB Risk Assessment form.

MCLA no longer requires COVID-19 vaccinations (or proof of vaccination) for employees, students, or visitors. It is strongly encouraged that all students be fully vaccinated for COVID-19 and remain up to date on COVID-19 vaccinations.

For students joining us from international regions please note that you are required to have TB testing. Either T-Spot or IGRA (Tuberculin) testing is accepted. Please include those results with your immunization record.

These forms are due no later than August 9th for fall semester enrollment and January 8th for spring semester enrollment. Massachusetts law requires immunization documentation to be on file in the health services office for students attending MCLA no later than two weeks prior to the start of the semester.

If we do not receive your Health Forms by August 9th you will not be allowed to move on to campus or attend classes.

Again, welcome to MCLA! Health Services is here to support you and we look forward to meeting you. Please do not hesitate to contact us with any questions or concerns at 413-662-5421.

Sincerely,

MCLA Health Services Staff
HEALTH RECORDS REQUIRED BY MCLA AND THE COMMONWEALTH OF MASSACHUSETTS

The Commonwealth of Massachusetts General Laws (Ch. 76 s 15) state that every full-time (9 or more credits) undergraduate or graduate student under age 30 and ALL Health Science students regardless of age and credits taken must comply with the following regulations before attending classes. If you are over 30 years of age and are NOT a Health Science major, you do not need to submit any immunization documentation or health forms.

VACCINE VERIFICATION – The following documentation of immunizations with appropriate dates are required by the Commonwealth of Massachusetts:

- 2 doses of measles, mumps, and rubella (MMR) or laboratory evidence of immunity.
- 2 doses of varicella vaccine or laboratory evidence of immunity or documentation by a health care provider stating that the student has a reliable history of chickenpox with the month and year documented.
- 1 dose of Tetanus, diphtheria, pertussis-Tdap within 10 years.
- 3 doses of Hepatitis B vaccine or laboratory evidence of immunity.
- 1 dose of meningitis ACWY (formerly MCV4) vaccine for students 21 years of age or younger. The dose must have been received on or after the student’s 16th birthday. The Law provides exemption for meningococcal vaccine only for students signing a waiver that can be reviewed and downloaded from the Health Services web page.
- T-spot or IGRA test - **REQUIRED FOR INTERNATIONAL STUDENTS ONLY**

PHYSICAL EXAMINATION

- A current physical is requested for all students attending MCLA.
- A current physical done within 6 months of the first day of practice is required for all MCLA Student Athletes.

HEALTH FORM

- The front portion of the Health Form is to be completed by the student and must include all information requested.
- The back portion of the Health Form includes record of physical exam and immunizations. This must be completed, signed, and dated by a health care provider.

OTHER FORMS

- The Health Information Use & Disclosure Form must be reviewed and signed.
- The TB Risk Assessment Form must be completed and signed.

You can download the Health Forms and view the requirements at:  
www.mcla.edu/Student_Life/wellness/healthservices

Students seeking exemption must provide the appropriate written documentation that they meet the standards for a medical or religious exemption set forth in MGL c 76 s 15C and 15D **before attending classes**.

Students who have previously discontinued enrollment and are being re-admitted must contact Health Services at (413) 662-5421 to determine the status of previous records.

375 Church Street, North Adams, MA 01247  
Phone 413-662-5421 ~ Fax 413-662-5572
HEALTH FORM

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 admission process.

Please Print:

Legal Name: _____________________________ Date of Birth: _____________________________

Last                               First                               MI

Current name: _____________________________ Social Security Number: _____________________________

Sex assigned at birth: ____________ Gender identity: __________________________________________

Home Address: _____________________________ Street _____________________________ City/Town _____________________________ State _____________________________ Zip code ___________

Home Phone: _____________________________ Student Cell: _____________________________

Emergency Contact: _____________________________ Relationship: _____________________________

Emergency Contact Cell: _____________________________ Work Number: _____________________________

For Students under 18 years of age:

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

Parent/Legal Guardian Signature: _____________________________________________

PERSONAL MEDICAL HISTORY

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<td>Anxiety/Panic Attacks</td>
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<td>Eye Problems</td>
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<td>Substance/Alcohol Abuse</td>
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<td>Head Injury</td>
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<td>Headaches (Recurrent)</td>
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<td>Hearing Deficit</td>
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<td>Birth Control</td>
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<td>Heart Disease</td>
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<td>Bleeding/Clotting Disorder</td>
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<td>Hepatitis</td>
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<td>High Blood Pressure</td>
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<td>Tuberculosis</td>
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<td>Chicken Pox</td>
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<td>Kidney Disease</td>
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<td>Ulcer/Gastritis</td>
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<td>Menstrual Disorder</td>
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<td>Urinary Tract Infection</td>
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<td>Joint/Bone Disease</td>
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<td>Mononucleosis</td>
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<td>Seizure Disorder</td>
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Please explain any YES answers from above: __________________________________________________________

List any regularly taken medication and the condition for which they are prescribed: __________________________________________________________

S__  A__  B__  C__  D__  E__  F__  G__  H__  I__

Allergies to medication: __________________________________________________________

Other allergies (IE: food, insects, etc.): __________________________________________________________

Student signature: _____________________________________________ Health Care Provider Signature acknowledging review: _____________________________________________
HEALTH FORM

Name: ____________________________ MCLA ID#: A __________

REQUIRED FOR COLLEGE ENTRY: TO BE FILLED OUT BY HEALTH CARE PROVIDER (MAY ALSO ATTACH IMMUNIZATION RECORD)

TDaP ____________________________ Varicella #1 ____________________________ Hepatitis B #1 ____________________________
Month/Year- must be within 10 years Month/Day/Year- must be 12 months of age Month/Day/Year

MMR#1 ____________________________ Varicella #2 ____________________________ Hepatitis B #2 ____________________________
Month/Day/Year- must be 12 months of age Must be 4 weeks after #1 Month/Day/Year

MMR#2 ____________________________ History of Varicella Disease ____________________________ Hepatitis B #3 ____________________________
Month/Day/Year- must be 4 weeks after #1 Month/Day/Year

* Meningitis ACWY Vaccine ____________________________
Must be received at age 16 or after

International Students Only: T-spot/IGRA ____________________________

Seasonal influenza vaccine: ____________________________

Signature of Health Care Provider: ____________________________ Date: ____________________________

* The Law provides exemption for Meningococcal vaccine only. Students opting for exemption must review and sign a waiver which can be downloaded from the Health Services webpage at: www.mcla.edu/Student_Life/wellness/healthservices. Laboratory evidence of immunity to MMR, Varicella and Hepatitis B satisfies the requirements. For immunization guidelines please refer to: www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-ma-school-requirements.pdf

Please attach copy of last performed physical examination.

Health Care Provider: Please acknowledge your review of the information provided with your signature on both sides of this form.

Height ____________ Weight ____________ BMI ____________ HR ____________ B/P ____________

Allergies to medication and type of reaction: ____________________________________________________________________________________________

__________________________________________________________________________________________

Allergies to foods and type of reaction: ____________________________________________________________________________________________

__________________________________________________________________________________________

Please list student’s current medications: ____________________________________________________________________________________________

__________________________________________________________________________________________

Is the student currently under treatment for any medical or emotional condition? No ☐ Yes ☐ If yes, please explain:

__________________________________________________________________________________________

Health Care Provider Signature: ____________________________ Date: ____________________________

Please print or type the Provider’s name, address and telephone: __________________________________________________________

____________________________________________________________
_____________________________________________________________________________________________________________________

MAIL TO: MCLA Health Services, 375 Church Street, North Adams, MA 01247-4100 Phone: 413-662-5421
FAX TO: 413-662-5572
EMAIL TO: healthservices@mcla.edu
For office use only.
To be signed upon receipt of Notice of Privacy Policy: ____________________________
Health Services

Tuberculosis/TB Risk Assessment Form

Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East?  ☐ YES ☐ NO
In what country were you born?  ________________________________

In the past 5 years have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?  ☐ YES ☐ NO

In the last 2 years have you lived with or spent time with someone who has been sick with TB/Tuberculosis?  ☐ YES ☐ NO

Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?  ☐ YES ☐ NO

In the past 1 year have you injected drugs that your doctor did not prescribe?  ☐ YES ☐ NO

Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility?  ☐ YES ☐ NO

If all of the above answers are NO you have completed this form. If you have answered YES to any of the above questions please proceed to SYMPTOM SCREENING below.

STUDENT NAME (print): ________________________________

STUDENT SIGNATURE: __________________ DATE: ____________

Symptom Screening – At this time do you have any of these symptoms?

Coughing for more than 2-3 weeks?  ☐ YES ☐ NO

Coughing up blood?  ☐ YES ☐ NO

Weight loss of more than 10 pounds for no known reason?  ☐ YES ☐ NO

Fever of 100 degrees F (38 degrees C) for over 2 weeks?  ☐ YES ☐ NO

Unusual or heavy sweating at night?  ☐ YES ☐ NO

Unusual weakness or extreme fatigue?  ☐ YES ☐ NO

If you answer “yes” to any of the questions above, you may be at increased risk for TB infection. Further testing may be required to rule out active TB.
Health Information Use and Disclosure

Student Name: _________________________________  
Date of Birth: ___________________________________

This form authorizes the use and disclosure of individually identifiable health information to Massachusetts College of Liberal Arts Student Wellness Center.

The Student Wellness Center at Massachusetts College of Liberal Arts, which I consider my Primary Care Provider, utilizes an electronic medical record-keeping system (EMR) in affiliation with other health care providers. This system allows the Student Wellness Center and any health care providers to access different components of any patient's “chart” and also provide up-to-date information to any provider who might see patients on an emergency basis and/or when the Student Wellness Center is closed. The Student Wellness Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition to the Student Wellness Center as they strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of the above-named individual’s health information as described below.

2. My health information will be shared only between the Student Wellness Center and other health care providers to facilitate continuity of care in the event I require treatment. It also will be available to affiliated specialists if I should require their services. This also will enable the Student Wellness Center to access my test results (laboratory tests, X-rays, cultures, etc.) in a timely manner to expedite my care.

3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted disease. This information is confidential and solely for the Student Wellness Center and will in no way affect the student’s college standing. Medical information will not be released from the Student Wellness Center to the college without my consent unless the information gathered would lead the Student Wellness Center to suspect that I was either a danger to myself or other members of the college community.

4. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to any other health care provider’s medical records department. Unless otherwise revoked, this authorization will expire on June 15th each calendar year and I will need to sign a new authorization for the following school year.

_____________________________________  Student Signature  __________________________         _____________  
Student name (please print)  
I accept this authorization

_____________________________________  Student Signature  __________________________         _____________  
Student name (please print)  
I decline this authorization

375 Church Street, North Adams, MA 01247 – 413-662-5421