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WASHINGTON COLLEGE

Student Health and Counseling – Health Form

Queen Anne Building
Chestertown, MD 21620
300 Washington Avenue

health_services@washcoll.edu
410-778-7261 Fax 410-810-7101

Please complete this form and return it to the Health Service. Forms should be returned by July 15 for students entering in the fall, and by January 1 for students entering in the spring. **This form must be completed and the immunization requirements met before you will be allowed to register.** All information contained in this form will be held in confidence and will not be released to anyone on- or off-campus without your knowledge and consent.

Student's Name_____Student's Cell #_____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Father/Guardian_____

Home Address_____

City_____State_____

Zip_____

Place of employment_____

Work #_____

Home #_____

Cell #_____

Mother/Guardian_____

Home Address _____

City_____State_____

Zip_____

Place of employment_____

Work #_____

Home #_____

Cell #_____

Consent for Treatment/Hospital Release

The undersigned herewith:

A. Grants permission to Washington College Health, Counseling, and Sports Medicine Services to provide medical care including administration of treatments and medications as necessary. This includes emergency room visits, lab work, x-rays, etc., which may need to be done at Chester River Hospital Center.

B. Authorizes the Student Health Services and Sports Medicine Services to exchange and release information to each other that may impact on my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/screening and Washington College Health Services health evaluation, immunization record, consent for treatment and questionnaire.

C. Understands that I must refrain from participation while ill or injured, whether receiving medical treatment or not, and during medical treatment until discharged from treatment or given permission by the College Nurse Practitioner or College Physician to restart participation while continuing treatment.

E. Acknowledge that the Washington College Health Service acts as your primary health care provider while you are attending Washington College as a student. Authorize the Washington College Health Service and Chester River Hospital Center to exchange and release to each other medical and insurance information about you for treatment and to ensure follow-up care. This form will remain valid until you graduate from Washington college or cease to be enrolled at the college, whichever is earlier.

F. Certifies that the answers to the questions on this Health Record are correct and true.
*Parent/Guardian must co-sign if student is under age 18.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature if student is a minor Date

PHYSICAL ASSESSMENT

*To be completed by your health care provider.

_____

Student's Last Name First Middle Date of Birth Sex Race

LIST DRUG & OTHER ALLERGIES: (Circle) None or List Allergies_____

_____

Latex allergy: Yes_____ No_____

Pulse_____Respirations_____BP_____Height_____Weight_____

EXAM	Normal ✓	Abnormal or additional elements
General	☐	
Eyes	☐	
Ears	☐	
NMT	☐	
Neck	☐	
Chest	☐	
Cardiovasc.	☐	
Breast	☐	
Abdomen	☐	
GU/GYN	☐	
Back	☐	
Musc.-skel./ext.	☐	
Skin	☐	
Neuro	☐	

Please list any prior surgeries, include dates: _____

_____

Is this student under treatment for any medical or emotional condition? If yes, explain. _____

_____

Limitations or Special Conditions (Please include any special dietary needs): _____

_____

Current Medications: (include dosage)_____

_____

Intercollegiate Athletics Participation Assessment:

_____Full Participation

_____Limited Participation (describe limitations, restrictions, time frame and if follow-up evaluation needed)

_____Participation Contraindicated (list reasons)

HEALTH CARE PROVIDER STATEMENT:

This student has been evaluated, found to be in good health, and able to participate in highly competitive intercollegiate athletics unless stipulated in assessment above.

_____ _____

Signature of physician/nurse practitioner Date

Provider's Name (please print) _____

Provider's Address_____

Phone #_____ext._____Provider's Fax #_____

IMMUNIZATION RECORD

Part I. To be completed by student. Please print.

Name _____
Last Name First Name Middle Name

Date of Birth _____/_____/_____ Social Security # _____ Phone (_____) - _____
Month Day Year \

Part II. To be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in English)

REQUIRED

A. TUBERCULOSIS

Does the Student have signs or symptoms of active tuberculosis disease? **NO** _____ **YES** _____

If YES proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated. All results and treatment plans must be included with this record before the student will be permitted on campus. Forms to be completed can be downloaded and printed from http://health.washcoll.edu/formsanddownloads.php

B. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations……_____/_____/_____ (Month Day Year)
2. Received tetanus-diphtheria booster **within the last 10 years**……..._____/_____/_____ (Month Day Year)

   or Tdap booster (recommended for ages 11-64 unless contraindicated)……_____/_____/_____ (Month Day Year)

C. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 - Immunized at 12 months or after and before 5 years……...#1 _____/_____/_____ (Month Day Year)
2. Dose 2 - Immunized at 5 years or later (at least 28 days after first dose)……...#2 _____/_____/_____ (Month Day Year)

D. POLIO **please circle vaccine type: Oral Inactivated E-IPV**

Completed primary series of polio immunization _____/_____/_____ (Month Day Year) Last booster _____/_____/_____ (Month Day Year)

E. HEPATITIS B

1. Dose #1 _____/_____/_____ (Month Day Year) Dose #2 _____/_____/_____ (Month Day Year) Dose #3 _____/_____/_____ (Month Day Year)
2. Surface antibody Date _____/_____/_____ (Month Day Year) Result: Reactive _____ Non-reactive _____

F. MENINGITIS VACCINE (Required by Maryland law for all college students)

1. Type of vaccine _____ Date _____/_____/_____ (Month Day Year)
2. Booster required if original dose given before age 16 Date _____/_____/_____ (Month Day Year)

G. VARICELLA

1. History of the disease? Yes _____ No _____ Varicella antibody _____/_____/_____ (Month Day Year) Result: Reactive _____ Non-reactive _____
2. Immunization Dose #1 _____/_____/_____ (Month Day Year) Dose #2 _____/_____/_____ (Month Day Year)

RECOMMENDED

H. HEPATITIS A

1. Immunization (hepatitis A) Dose #1 _____/_____/_____ (Month Day Year) Dose #2 _____/_____/_____ (Month Day Year)
2. Immunization (Combined hepatitis A and B vaccine)

   Dose #1 _____/_____/_____ (Month Day Year) Dose #2 _____/_____/_____ (Month Day Year) Dose #3 _____/_____/_____ (Month Day Year)

I. HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Dose #1 _____/_____/_____ (Month Day Year) Dose #2 _____/_____/_____ (Month Day Year) Dose #3 _____/_____/_____ (Month Day Year)

Health Care Provider _____ **Date** _____/_____/_____
Signature Month Day Year

Address _____ **Phone** _____

Name_____Date_____

PAST HISTORY: Please indicate problems you have now or may have had in the past. Please comment about any positive answers on a separate sheet of paper. This information is used solely as an aid to provide necessary health care while you are a student. It is considered confidential information and cannot be released to anyone without your permission.

Abdominal pain/Food intolerance	yes	no
AIDS, ARC, or positive HIV	yes	no
Alcohol Problem	yes	no
Allergies (seasonal)	yes	no
Anemia/Easy Bruising or Bleeding	yes	no
Anorexia	yes	no
Anxiety (frequent)/Nervousness	yes	no
Asthma/Wheezing	yes	no
Back Problems	yes	no
Bee Sting Reaction	yes	no
Bladder Infection (Cystitis)	yes	no
Bleeding Trait (Sickle Cell)	yes	no
Bronchitis	yes	no
Cancer (location_____)	yes	no
Chicken Pox	yes	no
Contacts/Glasses/Visual Problems	yes	no
Dental Problems	yes	no
Depression	yes	no
Diabetes	yes	no
Dizziness/Vertigo	yes	no
Drug dependency	yes	no
Dyslexia	yes	no
Ear Problems	yes	no
Eating Disorder	yes	no
Eczema	yes	no
Emotional or mental health issues	yes	no
Epilepsy	yes	no
Eye Problems	yes	no
Fainting/Dizziness	yes	no
Fibrocystic Breast Disease	yes	no
Food Intolerance	yes	no
Gall Bladder Disease	yes	no
Heat Stroke or Exhaustion	yes	no
Headaches (frequent)	yes	no
Stress / Migraine	yes	no
Hearing Loss	yes	no
Heart Problems	yes	no
Palpitations	yes	no
Rheumatic Heart	yes	no
Heart Murmur	yes	no
Chest pain with exercise	yes	no
Hepatitis	yes	no
Hernia	yes	no
High Blood Pressure	yes	no
Hypoglycemia	yes	no
Irritable Bowel Disorder	yes	no
Kidney problems	yes	no
Lyme Disease	yes	no
Marfan Syndrome	yes	no
Menstrual problems	yes	no
Mononucleosis – (give date_____)	yes	no
Nosebleeds	yes	no
Obesity (>20 lbs. overweight)	yes	no
Organ (loss of paired organ)	yes	no
Ovarian cyst	yes	no
Peptic Ulcer (gastric or duodenal)	yes	no
Phlebitis	yes	no
Pinched Nerve	yes	no
Pneumonia	yes	no
Rheumatic Fever	yes	no
Rheumatoid Arthritis	yes	no
Seizures or Convulsions	yes	no
Sinus Problems	yes	no
Stomach Problems	yes	no
Suicide Attempt	yes	no
Thyroid Problem	yes	no

Do you smoke cigarettes? yes no

How many last month? _____

How long have you smoked?_____

Do you use smokeless tobacco? yes no
How long?_____

Do you drink alcohol? yes no
Approximate number of drinks per occasion:_____

Number of drinking occasions per week:_____

Drug use (past or present) yes no

Have you ever been hospitalized? yes no
Please list reason and dates

_____
_____
_____
_____
_____
_____

Other problems not listed:_____
_____
_____

Have you ever had:
Any broken bones? yes no
Specify: _____

Dislocations? yes no
Specify:_____

Pain or swelling of muscle or joint?	yes	no
Injury to tendons, ligaments or cartilage	yes	no
AC separation or shoulder injury	yes	no
Blow to the head that knocked you out?	yes	no

Concussion(s)? yes no How many? _____

Injury to the neck or back?	yes	no
Spinal Fusion?	yes	no
Burner (hand or arm discomfort)	yes	no
Marfan Syndrome?	yes	no

***If you require any special accommodations please contact this office asap.**

Family History:
Have any of your relatives had:

Cancer	yes	no
Diabetes	yes	no
Epilepsy	yes	no
Have Sickle Cell Trait	yes	no
Heart Disease	yes	no
High Blood Pressure	yes	no
Kidney Disease	yes	no
Tuberculosis	yes	no

	Age	State of Health	Occupa-tion	Age at Death	Cause of Death	Date of Death
Father						
Mother						
Brothers						
Sisters						