

**CONFIDENTIAL
MEDICAL INFORMATION
(Please Print)**

HEALTH REPORT



**Williams College Health Center
105 The Knolls
Williamstown, MA 01267
Telephone 413-597-2206
Fax 413-597-2982**

<http://www.williams.edu/admin/health/>

FOR HEALTH SERVICES USE ONLY
Date received: COMPLETE
ALLERGIES:

MMR #1 #2 Titer
Hepatitis B #1 #2 #3 Titer
Tetanus Varicella
Meningitis: Vaccine Waiver
PPD: N/A Neg
Pos CXR INH
Athletic Clearance Exemption

PLEASE NOTE

Please complete and return the Health Form by August 11, 2008. Failure to provide the required immunization documentation will result in a registration hold.

First Year CDE Transfer Grad. Art

Name: _____ Gender: _____ Date of Birth: _____
Last First MI Month Day Year
Permanent Address: _____
Street

City State Zip Country

Home Phone: (____) _____ Student Cell Phone: (____) _____

PARENT/GUARDIAN/NEXT OF KIN INFORMATION (for contact in case of emergency)

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

ALTERNATE EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

CONSENT FOR MEDICAL CARE

Signature of parent/guardian required if student is under 18 years of age and is valid until age 18.

I hereby grant permission to the Director of Williams College Health Services or authorized representatives to provide such medical care as my daughter/son, _____ may require while she/he is a student at Williams College, including examinations, treatments, immunizations, etc. This also includes referral to an outside provider, a local hospital, hospitalization, anesthesia and/or surgery should it be necessary in the event of an illness or injury and I am unable to be reached.

Name of Parent/Guardian (print) _____ Signature: _____

MEDICAL HISTORY

FAMILY HISTORY

Student name _____

	Age	Occupation	State of Health	Age at Death	Cause of Death	Have any of your immediate relatives had any of the following:		Relationship
						Yes	No	
Parent						Alcohol/substance abuse		
Parent						Cancer		
Sisters						Diabetes		
						Kidney Disease		
Brothers						Neuromuscular Disorder		
Spouse/Partner						Mental Illness		
Children						Tuberculosis		

PERSONAL HISTORY Do you have now or have you ever had: (check all that apply)

- | | | | |
|--|---|---|--|
| 1. <input type="checkbox"/> Anemia | 10. <input type="checkbox"/> Depression | 19. <input type="checkbox"/> Impaired mobility/paralysis | 28. <input type="checkbox"/> Pneumothorax |
| 2. <input type="checkbox"/> Appendectomy | 11. <input type="checkbox"/> Diabetes | 20. <input type="checkbox"/> Kidney disease/stones | 29. <input type="checkbox"/> Seizure disorder |
| 3. <input type="checkbox"/> Arthritis | 12. <input type="checkbox"/> Disordered eating | 21. <input type="checkbox"/> Learning disability/ ADD/ADHD | 30. <input type="checkbox"/> Sickle cell disease |
| 4. <input type="checkbox"/> Asthma | 13. <input type="checkbox"/> Emotional/mental illness | 22. <input type="checkbox"/> Loss of paired organ (eye, kidney) | 31. <input type="checkbox"/> Thyroid disease |
| 5. <input type="checkbox"/> Blind/ Visual Impairment | 14. <input type="checkbox"/> Heart disease/problem | 23. <input type="checkbox"/> Malaria | 32. <input type="checkbox"/> Positive TB test |
| 6. <input type="checkbox"/> Cancer/malignancy | 15. <input type="checkbox"/> Hepatitis (Type ____) | 24. <input type="checkbox"/> Migraines/chronic headaches | 33. <input type="checkbox"/> Tuberculosis disease |
| 7. <input type="checkbox"/> Concussion | 16. <input type="checkbox"/> High blood pressure | 25. <input type="checkbox"/> Mononucleosis | 34. <input type="checkbox"/> Ulcer/stomach problem |
| 8. <input type="checkbox"/> Crohn's/Ulcerative Colitis/IBS | 17. <input type="checkbox"/> High cholesterol | 26. <input type="checkbox"/> Neuromuscular disease | 35. <input type="checkbox"/> UTIs (frequent/recurrent) |
| 9. <input type="checkbox"/> Deaf / Hearing impairment | 18. <input type="checkbox"/> HIV infection/disease | 27. <input type="checkbox"/> Phlebitis/deep vein clot | 36. <input type="checkbox"/> Other _____ |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates - attach sheet if needed):

INPATIENT HOSPITALIZATIONS: Please list all medical and/or psychiatric hospitalizations with dates and diagnoses:

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medications, antidepressants, etc.

ALLERGIES: None known Yes

If yes, please specify, including medications, insect venom, foods, etc. : _____ Type of reaction: _____

1a. Do you exercise? Never Occasionally 3-5 times/week
 Daily 1b. What type of exercise? _____

2a. How tall are you? _____ 2b. How much do you weigh? _____ lbs.

2c. What is your desired weight? _____ lbs.

3. Would you describe your weight as? Very underweight
 Underweight Just right Overweight Very Overweight

4. Do you do monthly breast self-exam (BSE)? No Yes

5. Have you been taught how to do breast self-exams(BSE)/testicular self-exams (TSE)?

6. Do you do BSE/TSE regularly? Yes No

7. Date of last PAP smear _____

8. Do you wear a seatbelt? Always Sometimes Never

9. Do you smoke cigarettes? No Yes How many/day? _____

10. Do you use recreational drugs? No Yes Which ones? _____

11. Do you drink alcohol? No Yes How often? _____
 When you drink, how many do you usually have? _____

12. Are you concerned about your drinking or drug use? No Yes

13. Do you often feel anxious, overwhelmed or depressed? No Yes

14. Are you currently seeing a counselor or therapist? No Yes

15. Have you ever been in therapy? No Yes Dates: _____

PHYSICAL EXAMINATION

STUDENT: _____ BIRTHDATE: _____ Date of Exam _____

A PHYSICAL EXAM WITHIN THE PAST SIX MONTHS IS REQUIRED.

Students are not eligible to participate in any Williams College sports program, including intramural and club sports, until this form has been completed and submitted to Health Services. The athletic trainer may have access to the physical examination report of students who elect to participate in athletics. **Students planning to participate in intercollegiate sports please note. Beginning Fall 2007, NCAA rules mandate that an intercollegiate athlete must have a physical within the 6 month period preceding their sport season. The following dates indicate the start of the sport season: Fall – August 25, 2008; Winter – November 1, 2008; Spring -- February 15, 2009**

HISTORY PLEASE ANSWER ALL QUESTIONS AND PROVIDE ALL PHYSICAL DATA REQUESTED ON THE FORM

	YES	NO
Prior exertional chest pain		
Prior exertional syncope/ near syncope		
Excessive, unexplained shortness of breath or fatigue with exercise		
Prior history of heart murmur or increased blood pressure		
Family history of premature death or mortality from cardiovascular disease in a relative younger than age 50		
Occurrence in family, specifically hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome or Marfan's syndrome		

SYSTEM	Record Result	DESCRIBE ABNORMALITY
Heart/Vascular System:		
Precordial auscultation		
Femoral Pulses		
Brachial BP – sitting		
Marfan's syndrome		
	Check if Normal	
Skin		
HEENT		
Lungs/Chest		
Breasts		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Height _____ ft. _____ in. Weight _____ lbs BMI _____

Lab work recommended: Hgb/Hct _____ Cholesterol _____ HDL _____ LDL _____ Urine: Glucose _____ Protein _____

CURRENT MAJOR AND CHRONIC PROBLEMS	ACUTE OR MINOR PROBLEMS

Recommendations for physical activity: (intercollegiate, intramural, club, phys ed): Unlimited Limited:

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.

ALLERGIES (medications, insect venom, foods, etc.) _____
 Type of Reaction _____ Does the student have an Epi-pen? Yes No

CURRENT MEDICATIONS (include vitamins, OTC's, contraceptives): _____

Do you have any dietary recommendations? Yes No Please specify: _____

Please note any additional recommendations regarding this student: _____

<p>Health Care Provider (please print) _____</p> <p>Address _____</p> <p>Phone (____) _____ FAX (____) _____</p> <p>Provider's Signature: _____</p> <p style="text-align: right;">Date _____</p>	<p>Mail Completed Form to: Williams College Health Center 105 The Knolls Williamstown, MA 01267</p>
---	---

**WILLIAMS COLLEGE
HEALTH CENTER**

105 The Knolls
Williamstown, MA 01267

IMMUNIZATION FORM

Phone 413-597-2206 • Fax: 413-597-2982
<http://www.williams.edu/admin/health/>

PART I: (to be completed by student)

NAME : (print)	DATE OF BIRTH:	ID #:
COUNTRY OF BIRTH:	If not born in USA, year entered the country: _____	

PART II: REQUIRED IMMUNIZATIONS (to be completed by a medical provider)

★ The following immunizations are required by Massachusetts Law. All dates must include month/day/year.
If documentation of immunization is not available or if a blood test indicates that you are NOT immune, you must be re-immunized.
Attached documents in a language other than English **must be translated into English** by the health care provider.

<p>★HEPATITIS B (Three doses required)</p> <p>Dose 1: ____/____/____</p> <p>Dose 2: ____/____/____ (Must be at least 1 month after #1)</p> <p>Dose 3: ____/____/____ (Must be at least 2 months after #2 and 4 months after #1)</p> <p>OR Lab test proving immunity (attach lab report)</p> <p><input type="checkbox"/> Immune – Titer value _____ Date: ____/____/____</p>	<p>★MMR (Measles, Mumps, Rubella)</p> <p>Two doses required, at least one month apart, after 12 months of age</p> <p>Dose 1: ____/____/____ Dose 2: ____/____/____</p> <p>OR Lab test proving immunity (attach lab reports)</p> <p>Measles: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p> <p>Mumps: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p> <p>Rubella: <input type="checkbox"/> Immune - Titer value _____ Date: ____/____/____</p>
<p>★TETANUS/DIPHTHERIA/PERTUSSIS</p> <p>A booster of Tetanus/Diphtheria within last ten years PLEASE NOTE: A one-time dose of Tdap is recommended, if at least 2-5 years since last Td</p> <p>Td Date ____/____/____ OR Tdap Date ____/____/____</p>	<p>★MENINGITIS</p> <p><input type="checkbox"/> Date vaccine administered: ____/____/____</p> <p><input type="checkbox"/> Menactra (MCV4) <input type="checkbox"/> Menomune (MPSV4) <input type="checkbox"/> Meningococcal (unspecified)</p> <p>OR <input type="checkbox"/> WAIVER, if not immunized, must be signed and returned with this form. Waiver can be downloaded at: www.williams.edu/dean/Firstyears.html</p>

<p>★ TUBERCULOSIS RISK ASSESSMENT (RAQ)</p> <p>The enclosed RAQ Form must be completed and returned with this form. If your answer to any of the four questions on Page 1 is YES, your health care provider must complete Page 2 of the RAQ. The RAQ can be downloaded at: www.williams.edu/dean/Firstyears.html</p>	<p>TO BE COMPLETED BY WILLIAMS HEALTH SERVICES</p> <p><input type="checkbox"/> LOW RISK <input type="checkbox"/> HIGH RISK <input type="checkbox"/> Hx of positive PPD</p> <p>Date of PPD: ____/____/____ <input type="checkbox"/> Positive ____mm <input type="checkbox"/> Negative</p> <p>Date of Chest X-ray: ____/____/____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal</p> <p>INH therapy <input type="checkbox"/> No <input type="checkbox"/> Yes Date started: _____ for # _____ months</p>
--	--

PART III: STRONGLY RECOMMENDED IMMUNIZATIONS (to be completed by a medical provider)

<p>VARICELLA (Chicken Pox)</p> <p>History of Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes at age: _____</p> <p>OR</p> <p>Lab test proving immunity (attach lab report)</p> <p><input type="checkbox"/> Immune Titer value _____ Date: ____/____/____</p> <p>OR</p> <p>Vaccine Dose 1 ____/____/____</p> <p>Vaccine Dose 2 ____/____/____</p>	<p>HEPATITIS A</p> <p>Hepatitis A Vaccine (at least 6 months apart)</p> <p>Dose 1 ____/____/____ Dose 2 ____/____/____</p> <p>Combined Hepatitis A and B Vaccine</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>	<p>HUMAN PAPILLOMAVIRUS (HPV)</p> <p>Vaccine (at 0, 2 and 6 month intervals)</p> <p><input type="checkbox"/> Gardasil <input type="checkbox"/> Other</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>
--	--	--

POLIO
(Primary series, doses at least 28 days apart. Three primary series are acceptable.)

1. OPV alone (oral Sabin three doses): #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
M D Y M D Y M D Y

2. IPV/OPV sequential: IPV #1 ____/____/____ IPV #2 ____/____/____ OPV #3 ____/____/____ OPV #4 ____/____/____
M D Y M D Y M D Y M D Y

3. IPV alone (injected Salk four doses): #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____
M D Y M D Y M D Y M D Y

IMPORTANT NOTICE: FAILURE TO COMPLY WITH THE MASSACHUSETTS IMMUNIZATION LAW WILL RESULT IN A HOLD BEING PLACED ON YOUR REGISTRATION