Due date:
Fall - July 15th; Spring - January 1st

Attach Photo Here

STUDENT HEALTH AND COUNSELING HEALTH FORM

Queen Anne Building
300 Washington Avenue
Chestertown, MD 21620

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

Please complete this form and return it to the Health Service. **This form must be completed and the immunization requirements met before you will be allowed to attend classes.** 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 Last Name_____First_____Middle_____Preferred Name_____
Date of Birth_____Sex assigned at birth_____Current gender identity: M/F/T Other _____
Race_____Student's Cell #_____Preferred Pronoun_____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Parent/Guardian 1_____Parent/Guardian 2 _____
Home Address_____Home Address _____

_____

_____

Place of employment_____Place of employment _____
Work #_____Work # _____
Home #_____Cell #_____Home #_____Cell # _____

Consent for Treatment/Hospital Release Permission to email

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 local facilities including University of Maryland Shore Regional Health facilities, local imaging and lab locations.

B. Authorizes the Student Health Services, Disabilities Services and/or 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 athletics 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 University of Maryland Shore Regional Health Centers to exchange and release to each other medical and insurance information about you for treatment and to ensure follow-up care and grants permission for Health services to email appointment reminders via unencrypted messages. 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 Co Sign Signature if student is a minor Date

FOR LICENSED HEALTHCARE PROVIDER TO COMPLETE

TO THE EXAMINING HEALTH CARE PROVIDER: Please review the student's history and complete this report. Please comment on all positive answers. *This student has been accepted.* The information supplied *will not* affect his/her status. It will be used as a background for providing continued physical and mental health care on campus. **Physical Exam must be done within 6 months prior to arriving on campus.**

Name_____**Date of Birth**_____**Current Gender Identity**_____

Height_____**Weight**_____**Blood Pressure**_____**Pulse**_____

Allergies_____

Current medications_____

_____

Visual Acuity: Recommended

□ With □Without Correction

□ Glasses □ Contact Lenses

Right 20/ Left 20/ Both 20/

Clinical Evaluation ……	**Normal**	**Record Abnormal Findings ……**
Appearance (Report Marfan Stigmata)		
Skin		
Head, ears, Eyes, Nose, Hearing		
Mouth, Teeth and Gums		
Neck and Thyroid		
Lungs/Chest		
Breasts		
Heart (supine and standing)		
Abdomen		
Genitalia		
Back/Spine		
Extremities/Musculoskeletal		
Neurologic		
Emotional/Psychological		

I have reviewed the medical history, immunizations, conducted the TB screen and examined this student. The information on this form is accurate, full and complete to the best of my knowledge. Sign_____Date_____

Print Provider's Name_____Phone_____Fax_____

Office Address_____

TUBERCULOSIS SCREENING AND IMMUNIZATION INFORMATION

Name _____
Last First MI

Date of Birth _____
month/day/year social security # Phone

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)

IMMUNIZATION REQUIRED FOR ALL STUDENTS

A. for international students only

1. BCG vaccine received? no____yes____date given_____/_____/ _____

B. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations _____/_____/_____
2. Received tetanus-diphtheria booster **within the last 10 years** _____/_____/_____

or Tdap booster (recommended for ages 11-64 unless contraindicated)_____/_____/_____

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

1. Dose 1 - Immunized at 12 months or before 5 years _____/_____/ _____
2. Dose 2 - Immunized at 4 years or later (at least 28 days after first dose)_____/_____/_____

D. POLIO please circle vaccine type: Oral Inactivated

1. Completed primary series of polio immunizations ____/_____/ _____ Last booster_____/_____/_____

E. HEPATITIS B

1. Dose #1_____/_____/_____Dose #2_____/_____/_____Dose #3_____/_____/ _____

OR Surface antibody_____/_____/_____ Result: Reactive_____Non-reactive _____

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

1. Name of vaccine:_____Date_____/_____/_____
2. Booster required if original dose given before 16 Date____/_____/ _____

G. VARICELLA (Chicken Pox)

Disease? Yes_____Date:_____/_____/_____if date unknown provide titer results and
Reactive (date):____/_____/_____NonReactive (date):_____/_____/_____
Vaccine: Dose #1_____/_____/_____Dose #2_____/_____/ _____

RECOMMENDED

H. HEPATITIS A

1. Immunization (Hepatitis A) Dose #1_____/_____/_____Dose #2_____/_____/ _____
2. Immunization (Combined Hepatitis A and B)

Dose #1_____/_____/ _____ Dose #2_____/_____/ _____ Dose #3_____/_____/_____

I. HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Name of vaccine: _____
Dose #1_____/_____/_____Dose #2_____/_____/_____Dose #3_____/_____/_____

J. MENINGITIS B VACCINE

Name of vaccine: _____
Dose #1_____/_____/_____Dose #2_____/_____/_____Dose #3_____/_____/_____

Health Care Provider _____ _____
Signature Date

Address_____
Phone _____

Name_____ Date_____

PAST HISTORY SECTION TO BE COMPLETED BY STUDENT/GUARDIAN: 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 can not 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, EPi pen	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
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:		
Palpitations	yes	no
Rheumatic Heart	yes	no
Heart Murmur	yes	no
Chest pain with exercise	yes	no
(if any of above heart issues, must attach cardiologist report)		
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
Last seizure and type_____		
Sinus Problems	yes	no
Sickle Cell trait or disease	yes	no
Stomach Problems	yes	no
Suicide Attempt	yes	no
Date:_____		
Thyroid Problem	yes	no
Do you smoke?	yes	no
How long have you smoked?_____		
How often_____		
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
Drug of choice:_____		

Please list hospitalizations or surgeries and date

_____

_____

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?_____How many?_____		
Injury to the neck or back?	yes	no
Spinal Fusion?	yes	no

***If you require any kind of special accommodations please contact this office asap and contact the Office of Disabilities Services to register for accommodations.**

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	Occu-pation	Age at Death	Cause of Death
Father					
Mother					
Brothers					
Sisters					