



REQUIRED HEALTH INFORMATION CHECK LIST



For your convenience below is a check list of the information that needs to be returned to the Hamel Health Center.

Please return all of the information together
By August 1, 2010

Health Examination Report

- Complete Physical **within the past year**
 - ❖ If you are not due for your physical until after the deadline date of August 1, 2009, we will accept last year's physical until a new one can be submitted.
- Be sure all your Immunizations are **up-to-date and complete.**

Signed Meningococcal Waiver if not immunized

Tuberculosis Risk Questionnaire

If you are a Resident Student you must submit a copy of both sides of your Health Insurance card.

- If you carry your own health insurance please go on-line to www.gallagherkoster.com to waive the school insurance (which is provided automatically without waiver).
- Questions regarding student health insurance (Gallagher Koster) should be directed to the College Bursar at 978-837-5105

Important Student Athlete Information

The Athletic Department health forms and requirements are **in addition** to the College Health Examination Report. Therefore, as a Merrimack College student-athlete you are required to submit **both** forms for participation in College and in athletics.

- The Athletics sports physical form can be found on the Merrimack College Athletic Website.
- Questions regarding this form should be directed to the Athletic Department at 978-837-5341.

Please give dates or details of any:

Serious Illness _____

Hospitalizations _____

Operations _____

Injuries _____

Allergies to Medication; please list _____

Other Allergies _____

(If you indicated a Serious Illness on this form please read and sign Medical Release Form below.)

MEDICAL RELEASE FORM:

Standard procedure is that we notify Campus Police as well as Residence Life of any potentially serious health condition. This is necessary in case of an emergency or exacerbation of your condition. Since our records are completely confidential, we need your permission to notify these departments. This enables us to provide you with the best possible medical services.

I give the Hamel Health Center permission to provide basic medical information to the above named departments so that they may be aware of it in the event of an emergency.

Student's Signature _____ Date _____

List all medications you are currently taking _____

Do you smoke? Yes _____ No _____ How many cigarettes a day? _____

Do you drink alcohol? Yes _____ No _____ How often? _____ Amount? _____

Do you exercise? Yes _____ No _____ What type? _____ How often? _____

Are you concerned about your eating patterns? Yes _____ No _____ Your weight? Yes _____ No _____

Will you require specific assistance or modifications at college due to a medical condition or disability?

Yes _____ No _____ Please specify: _____

Have you ever been treated for depression or other emotional problems? Yes _____ No _____

Do you follow any special diet? Yes _____ No _____

Are you presently under treatment for any medical or psychological problem? Yes _____ No _____

Describe _____

IN CASE OF EMERGENCY, CALL

Father _____ Work # _____ Home # _____ Cell # _____

Mother _____ Work # _____ Home # _____ Cell # _____

Name of alternate person _____ Work # _____ Home # _____ Cell # _____

A copy of both sides of your insurance card is required if you will be living on campus. Please attach it to this form.

Primary insurance carrier _____ Certificate Number _____ Subscriber _____

(THIS AUTHORIZATION MUST BE COMPLETED BY THE PARENT OR GUARDIAN OR THE STUDENT)

Permission for emergency surgery, when parent or guardian cannot be reached.

(N.B. Reasonable effort to contact parents or guardian will always be made.)

This is to certify that I, _____ give permission for emergency surgery and for necessary medical treatment of illnesses or injuries for (Student's Full Name) _____

REQUIRED: _____ DATE: _____
SIGNATURE PARENT () GUARDIAN ()

_____ DATE: _____
SIGNATURE STUDENT

THE FOLLOWING IMMUNIZATIONS ARE MANDATORY AND THIS FORM MUST BE FILLED OUT COMPLETELY

Proof of immunity is required by Massachusetts Law.

Dates must include month and year.

Student Name _____

Month/Year

Tetanus-Diphtheria

- 1. Completed primary series of tetanus-diphtheria immunizations. _____/____
- 2. Received tetanus-diphtheria booster within the last 10 years. _____/____
- 3. If the student is due for Td booster a single dose of Tdap instead of Td is recommended by ACIP _____/____

MMR (Measles, Mumps, Rubella) (two doses required)

- 1. Dose 1 given at 12 months after birth or later _____/____
- 2. Dose 2 _____/____
 - or documentation of antibody titer attached _____

Polio

- 1. Completed primary series of polio immunization. Yes _____ No _____ Date of last booster _____/____

Hepatitis B Vaccine

_____ Completed vaccination series #1. _____/____
#2. _____/____
#3. _____/____

- or report of positive immune titer (include copy) _____

Meningococcal vaccine mandatory

- or signed waiver declining the vaccine enclosed _____ _____/____

HPV Vaccine (Recommended for Women)

_____ Completed vaccination series #1. _____/____
#2. _____/____
#3. _____/____

Tuberculosis (Tine or monovac not acceptable.) If high risk mandatory.

- 1. PPD (Mantoux) test within the last 12 months. Result: Negative _____ Positive _____ _____/____
- 2. Positive PPD, or received BCG vaccine in the past. Chest X-ray required.
Result of chest X-ray: Negative _____ Positive _____ Give date of chest X-ray. _____/____
Is patient presently on medication? _____

Varicella (Chicken Pox) Had disease Yes _____ No _____

Vaccinated #1 _____/____ #2 _____/____

Health Care Provider

Name _____ Signature _____

PHYSICIAN'S REPORT

Must be fully completed by a physician within 6 months prior to arrival at college

Student's Name _____ Date _____

How long have you know the applicant? _____

System	Conditon of	Comments
Skin	_____	_____
Head	_____	_____
Eyes	_____	_____
Ears	_____	_____
Nose/Sinuses	_____	_____
Throat/Tonsils	_____	_____
Neck/Thyroid	_____	_____
Teeth/Gums	_____	_____
Lymph Nodes	_____	_____
Breasts	_____	_____
Lungs/Chest	_____	_____
Heart Rate/Rhythm	_____	_____
Abdomen	_____	_____
Hernia	_____	_____
Spine	_____	_____
Extremities/Joints	_____	_____
Neurological	_____	_____
Psychological	_____	_____

Menstrual History
 _____ Frequency
 _____ Difficulties
 _____ Do you take medication
 _____ If yes please state name
 of medication
 _____ Do you take birth control pills

Eyes
 Glasses Yes _____ No _____
 Contacts Yes _____ No _____
 Eye Glass Prescription _____

Lab Work Recommended
 Hemoglobin or Hematocrit
 _____ gm%
 Urinalysis
 _____ Albumin
 _____ Sugar
 _____ Microscopic

_____ Height _____ Weight _____ Pulse _____ Blood Pressure

The applicant may participate in:

____ routine college activities, including intramural sports WITHOUT restriction

____ routine college activities, including intramural sports, WITH the following restrictions: _____

____ Intercollegiate sports regulated by the NCAA WITHOUT restriction*

____ Intercolleagiante sports regulated by the NCAA WITH the following restrictions*: _____

*** Athletes are required to complete an additional sports form available through the Merrimack College Athletic Website**

Please list all allergies to medication _____

Please list all medications currently being taken and dosage _____

Do you have any recommendations regarding the care of this student while at college. _____

PHYSICIAN'S SIGNATURE _____

ADDRESS _____

TELEPHONE NUMBER _____

FAX NUMBER _____

PRINT LAST NAME _____ DATE _____

RETURN ALL INFORMATION TO

HAMEL HEALTH CENTER
MERRIMACK COLLEGE
315 TURNPIKE STREET
NORTH ANDOVER, MA 01845-5800
FAX: 978-837-5209
PHONE: 978-837-5441

Tuberculosis Risk Questionnaire

A person who has been infected with Tuberculosis (T) may show no outward symptoms. However, infection can later lead to severe illness. To detect the problem before a person becomes ill, we perform a tuberculosis skin test. Instead of testing all people, as we have in the past, we recommend that only some people should have a skin test. If a test is warranted, a person will be tested with the intermediate PPD (Mantoux) skin test, because it is the most accurate available. We no longer recommend the use of the less accurate multiple puncture skin tests such as the Tine or Monovac.

To help your health care provider determine if you need to be skin tested
Please answer the following questions:

Name: _____	YES	NO
Are you non-U.S. born from a high prevalence country* (especially, but not limited to those who arrived in the last five years)? *Africa, Asia except Japan, Central/South America, Mexico, Eastern Europe, Caribbean, Middle East	<input type="checkbox"/>	<input type="checkbox"/>
Have you lived with or spent time with anyone who possibly or definitely had Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Does anyone living in your household have a positive skin test for Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
Have you lived or had extensive travel outside the USA within the past five years to countries with high prevalence of TB?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your household have AIDS or HIV infection?	<input type="checkbox"/>	<input type="checkbox"/>
Do you or anyone in your household use intravenous drugs or other street drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you worked or lived in a potentially high-risk congregate setting such as prison/jail, long-term care facility, homeless shelter, residential facility for persons with HIV/AIDS, drug treatment center, etc.?	<input type="checkbox"/>	<input type="checkbox"/>

If you have had a “positive” skin test for tuberculosis in the past, inform your health care provider.
You will not need another test.

HEALTH CARE PROVIDER PLEASE NOTE:
LOW RISK IS ANSWERING “NO” TO ALL OF THE ABOVE QUESTIONS.
HIGH RISK IS ANSWERING “YES” TO ONE OR MORE OF THE ABOVE QUESTIONS.