

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 admissions process.

Please Print:

Legal Name: _____ Date of Birth: _____
Last First Initial

Preferred Name: _____ Social Security Number: _____

Gender: Male Female Transgender Other: _____

Home Address: _____
Street City State Zip Code

Home Phone Number: _____ Student Cellphone Number: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Cellphone Number: _____ Business 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.

Signature: (Parent or Legal Guardian) _____

PERSONAL MEDICAL HISTORY	Yes	No		Yes	No		Yes	No
Anxiety/Panic Attacks			Eye Problems			Substance/Alcohol Abuse		
Anemia			GERD			Surgery		
Asthma/Other Lung Disease			Head Injury			Appendectomy		
Attention Deficit Disorder			Headaches (Recurrent)			Tonsillectomy		
Back Injury/Problem			Hearing Deficit			Other:		
Birth Control			Heart Disease					
Bleeding/Clotting Disorder			Hepatitis			Thyroid Disease		
Blood Transfusion			High Blood Pressure			Tuberculosis		
Chicken Pox			Kidney Disease			Ulcer/Gastritis		
Depression			Menstrual Disorder			Urinary Tract Infection		
Diabetes			Mental Health Disorder			Other significant problem		
Joint/Bone Disease			Mononucleosis			please specify:		
Ear, Nose, Throat Problems			Seizure Disorder					
Eating Disorder			Smoker					

Please explain any YES from above: _____

List any regularly taken medications and the condition for which they are prescribed: _____

Allergies to Medication: _____

Other Allergies (IE: food, insects ect): _____

Student Signature

Healthcare Provider's Signature-acknowledging review

For office use only: To be signed upon receipt of Notice of Privacy Policy

Student Signature: _____ Date: _____

A# _____

Name: _____ Date of Birth: _____

REQUIRED FOR COLLEGE ENTRY: TO BE FILLED OUT BY THE HEALTH CARE PROVIDER:

TDaP _____ Month/YR-must be within 10 yrs	Varicella #1 _____ Month/Day/YR-must be 12 month of age	Hepatitis B #1 _____ Month/Day/YR
MMR #1 _____ Month/Day/YR-must be 12 months of age	Varicella #2 _____ Must be 4 weeks after #1	Hepatitis B #2 _____ Month/Day/YR
MMR #2 _____ Must be 4 weeks after #1	OR	Hepatitis B #3 _____ Month/Day/YR
	History of Varicella Disease _____ Month/YR	
*Meningococcal Vaccine _____ Within 5 years	Tuberculin(TB) skin test #1 _____ #2 _____ OR IGRA	
<u>INTERNATIONAL STUDENTS ONLY</u>		
Signature of Healthcare 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 web page at: www.mcla.edu/Student_Life/wellness/healthservices. Laboratory evidence of immunity to MMR, Varicella and Hepatitis B satisfies the requirements. For immunizations guidelines please refer to <http://www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines/ma-school-requirements.pdf>

Health Care Provider: Please review the information on Side 1 and acknowledge with your signature at the bottom of the page. Complete this side, commenting on positive responses. Please describe any significant abnormalities.

HGT _____ WT _____ BMI _____ HR _____ B/P _____

	nl	abnl	comments
HEENT			
Skin			
Respiratory			
Cardiovascular			
Abdominal			
Genitourinary			
Musculoskeletal			
Metabolic/endocrine			
Neurological			

Allergies to medication and type of reaction: _____

Allergies to foods and type of reaction: _____

Is the patient on medications at this time? Please list _____

Is the patient now under treatment for any medical or emotional condition? Please explain: _____

Health Care Provider's signature: _____ Date of Exam: _____

Please print or type the Provider's name & address _____

Tel#: _____

Please note: Registration at MCLA is not valid until complete form is received by Health Services

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Student Signature: _____ Date: _____

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Student Signature: _____ Date: _____