MCLA MASSACHUSETTS COLLEGE of Liberal Arts

A#_____

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 [] Self Identify: _____

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 etc.): _____

_____ _____

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: _____

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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

History of Varicella Disease _____ Month/YR

Hepatitis B #3 _____ Month/Day/YR

*Meningococcal Vaccine _____ Within 5 years

Tuberculin(TB) skin test #1_____ #2_____ **OR** IGRA _____

INTERNATIONAL STUDEN TS ONLY

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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A#_____

Mail to: MCLA Health Services, 375 Church Street, North Adams, MA 01247-4100 Tel: 413-662-5421 Fax: 413-662-5572

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Student Signature: _____ Date: _____