MCLA
MASSACHUSETTS COLLEGE OF LIBERAL ARTS

A MESSAGE FROM MCLA HEALTH SERVICES

Welcome to MCLA! The Health Services staff would like to congratulate you on your acceptance and wish you a rewarding and successful academic year.

As you are now part of the MCLA family, it is our goal to provide you with the best care possible. In making every attempt to do so we are asking you to review and sign the **Health Information Use and Disclosure** form that is included for download. This release form will allow MCLA Health Services the ability to access your hospital records should you require emergency care from one of the local hospitals. This release complies with HIPPA guidelines, while allowing us to provide you with a continuum of care and assist you in any follow-up care required. Please note this information will be maintained in the strictest confidence and will only be used as needed for the continuation of your care.

All new students taking 9 or more credits and who are under 30 years of age are required to complete Health Services forms and requirements before attending classes. Of note if you are a Health Science major you are required to complete Health Services forms and requirements regardless of age or credits. The required **Health Form** is enclosed and is also conveniently located in the MCLA Health Services website. In addition to the Health Form, please have your physician attach a copy of your most recent physical examination. All students also need to complete and sign the **TB Risk Assessment form**.

MCLA is requiring proof of COVID-19 vaccination. Please submit a copy of your *COVID-19 Vaccination Record Card* with your name, date of birth and MCLA A# to Health Services at HealthServices@mcla.edu by August 1, 2021.

For students joining us from international regions please note that you are required to have TB testing. Either T-Spot or IGRA (Tuberculin) testing is accepted. Please include those results with your immunization record.

These forms are due no later than July 1st for fall semester enrollment and January 8th for spring semester enrollment.

Again, welcome to MCLA! Health Services is here to support you and we look forward to meeting you. Please do not hesitate to contact us with any questions or concerns at 413-662-5421.

Sincerely,

MCLA Health Services Staff

MASSACHUSETTS COLLEGE OF LIBERAL ARTS

HEALTH SERVICES

HEALTH RECORDS REQUIRED BY MCLA AND THE COMMONWEALTH OF MASSACHUSETTS

The Commonwealth of Massachusetts General Laws (Ch. 76 s 15) state that every full-time (9 or more credits) undergraduate or graduate student under age 30 and ALL Health Science students regardless of age and credits taken must comply with the following regulations before attending classes. If you are over 30 years of age and are NOT a Health Science major you do not need to submit any immunization documentation or health forms.

VACCINE VERIFICATION – The following documentation of immunizations with appropriate dates are required by the Commonwealth of Massachusetts:

- 2 doses of measles, mumps and rubella (MMR) or laboratory evidence of immunity.
- 2 doses of varicella vaccine or laboratory evidence of immunity or documentation by a health care provider stating that the student has a reliable history of chickenpox with the month and year documented.
- 1 dose of Tetanus, diphtheria, pertussis-Tdap within 10 years.
- 3 doses of Hepatitis B vaccine or laboratory evidence of immunity.
- 1 dose of meningitis ACWY (formerly MCV4) vaccine for students 21 years of age or younger. The dose must have been received on or after the students 16th birthday. The Law provides exemption for meningococcal vaccine only for students signing a waiver that can be reviewed and downloaded from the Health Services web page.
- Photocopy of your *COVID-19 Vaccination Record Card.*
- T-spot or IGRA test - REQUIRED FOR INTERNATIONAL STUDENTS ONLY

PHYSICAL EXAMINATION

- A current physical is requested for all students attending MCLA.
- A current physical done within 6 months of the first day of practice is required for all MCLA Student Athletes.

HEALTH FORM

- The front portion of the ***Health Form*** is to be completed by the student, and ***must*** include all information requested.
- The back portion of the ***Health Form*** includes record of physical exam and immunizations. This must be completed, ***signed and dated*** by a health care provider.

OTHER FORMS

- The ***Health Information Use & Disclosure Form*** must be reviewed and signed.
- The ***TB Risk Assessment Form*** must be completed and signed.

You can download the Health Forms and view the requirements at:
www.mcla.edu/Student_Life/wellness/healthservices

Students seeking exemption must provide the appropriate written documentation that he or she meets the standards for medical or religious exemption set forth in MGL c 76 s 15C and 15D ***before attending classes.***

Students who have previously discontinued enrollment and are being re-admitted must contact Health Services at (413) 662-5421 to determine the status of previous records.

375 Church Street, North Adams, MA 01247
Phone 413-662-5421 ~ Fax 413-662-5572

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A#_____

HEALTH FORM

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 admission process.

Please Print:

Legal Name: _____ Date of Birth: _____
Last *First* *MI*

Name used: _____ Social Security Number: _____

Gender: Male ☐ Female ☐ Self-identify: _____

Home Address: _____
Street City/Town State Zip code

Home Phone: _____ Student Cell: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Cell: _____ Work 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.

Parent/Legal Guardian Signature: _____

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 answers from above: _____

_____

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

_____

Allergies to medication: _____

Other allergies (IE: food, insects, etc.): _____

Student signature: _____ Health Care Provider Signature acknowledging review: _____

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HEALTH FORM

Name: _____ **MCLA ID#: A** _____

REQUIRED FOR COLLEGE ENTRY: TO BE FILLED OUT BY HEALTH CARE PROVIDER (MAY ALSO ATTACH IMMUNIZATION RECORD)

TDaP _____
Month/Year-must be within 10 years

MMR#1 _____
Month/Day/Year- must be 12 months of age

MMR#2 _____
Month/Day/Year- must be 4 weeks after #1

*Meningitis ACWY Vaccine _____
Must be received at age 16 or after

Varicella #1 _____
Month/Day/Year-must be 12 months of age

Varicella #2 _____
Must be 4 weeks after #1

OR

History of Varicella Disease _____
Month/Year

Hepatitis B #1 _____
Month/Day/Year

Hepatitis B #2 _____
Month/Day/Year

Hepatitis B #3 _____
Month/Day/Year

International Students Only: T-spot/IGRA _____

COVID-19 Vaccination: PLEASE SUBMIT COPY OF *COVID-19 VACCINATION RECORD CARD* Seasonal influenza vaccine: _____

Signature of Health Care 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 webpage at: www.mcla.edu/Student_Life/wellness/healthservices. Laboratory evidence of immunity to MMR, Varicella and Hepatitis B satisfies the requirements. For immunization guidelines please refer to: www.mass.gov/eohhs/docs/dph/cdc/immunization/guidelines-ma-school-requirements.pdf

Please attach copy of last performed physical examination.

Health Care Provider: Please acknowledge your review of the information provided with your signature on both sides of this form.

Height _____ Weight _____ BMI _____ HR _____ B/P _____

Allergies to medication and type of reaction: _____

_____

Allergies to foods and type of reaction: _____

_____

Please list student's current medications: _____

_____

Is the student currently under treatment for any medical or emotional condition? No ☐ Yes ☐ If yes, please explain:

_____

Health Care Provider Signature: _____ **Date:** _____

Please print or type the Provider's name, address and telephone: _____

_____

MAIL TO: MCLA Health Services, 375 Church Street, North Adams, MA 01247-4100 Phone: 413-662-5421
FAX TO: 413-662-5572
EMAIL TO: healthservices@mcla.edu

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

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Health Services
Tuberculosis/TB Risk Assessment Form

Were you born in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East? In what country were you born? _____	☐ YES	☐ NO
In the past 5 years have you lived or traveled in Africa, Asia, Central America, South America, Mexico, Eastern Europe, Caribbean or the Middle East for more than one month?	☐ YES	☐ NO
In the last 2 years have you lived with or spent time with someone who has been sick with TB/Tuberculosis?	☐ YES	☐ NO
Are you taking any medications that your doctor said could weaken your immune system or increase your risk for infections?	☐ YES	☐ NO
In the past 1 year have you injected drugs that your doctor did not prescribe?	☐ YES	☐ NO
Have you ever lived or worked in a prison, jail, homeless shelter or long-term care facility?	☐ YES	☐ NO

*If all of the above answers are **NO** you have completed this form. If you have answered **YES** to any of the above questions please proceed to **SYMPTOM SCREENING** below.*

STUDENT NAME (print):_____

STUDENT SIGNATURE: _____DATE:_____

Symptom Screening – At this time do you have any of these symptoms?

Coughing for more than 2-3 weeks?	☐ YES	☐ NO
Coughing up blood?	☐ YES	☐ NO
Weight loss of more than 10 pounds for no known reason?	☐ YES	☐ NO
Fever of 100 degrees F (38 degrees C) for over 2 weeks?	☐ YES	☐ NO
Unusual or heavy sweating at night?	☐ YES	☐ NO
Unusual weakness or extreme fatigue?	☐ YES	☐ NO

If you answer "yes" to any of the questions above, you may be at increased risk for TB infection. Further testing may be required to rule out active TB.

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Health Information Use and Disclosure

Student Name: _____
Date of Birth: _____

This form authorizes the use and disclosure of individually identifiable health information to Massachusetts College of Liberal Arts Student Wellness Center.

The Student Wellness Center at Massachusetts College of Liberal Arts, which I consider my Primary Care Provider, utilizes an electronic medical record-keeping system (EMR) in affiliation with other health care providers. This system allows the Student Wellness Center and any health care providers to access different components of any patient's "chart" and also provide up-to-date information to any provider who might see patients on an emergency basis and/or when the Student Wellness Center is closed. The Student Wellness Center also can promptly access test results as they are completed, bypassing clerical turnaround times. EMR is a welcome addition to the Student Wellness Center as they strive to provide efficient, comprehensive healthcare to our students.

1. I authorize the use and/or disclosure of the above-named individual's health information as described below.

2. My health information will be shared only between the Student Wellness Center and other health care providers to facilitate continuity of care in the event I require treatment. It also will be available to affiliated specialists if I should require their services. This also will enable the Student Wellness Center to access my test results (laboratory tests, X-rays, cultures, etc.) in a timely manner in order to expedite my care.

3. I understand that the information in my health record may include information regarding the use of drug and alcohol treatment services, HIV/AIDS treatment, mental health services, reproductive health services, and treatment for sexually transmitted disease. This information is confidential and solely for the Student Wellness Center and will in no way affect the student's college standing. Medical information will not be released from the Student Wellness Center to the college without my consent unless the information gathered would lead the Student Wellness Center to suspect that I was either a danger to myself or other members of the college community.

4. I understand that this authorization is subject to revocation at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to any other health care provider's medical records department. Unless otherwise revoked, this authorization will expire on June 15th each calendar year and I will need to sign a new authorization for the following school year

_____	_____	_____
Student name (please print)	Student Signature	Date

I accept this authorization

_____	_____	_____
Student name (please print)	Student Signature	Date

I decline this authorization