OFFICE USE ONLY	
@ _____	Name: _____
Entering Semester: _____	Banner Complete: Yes / No
Letter sent/missing: _____	(complete now: Yes / No)

FITCHBURG STATE UNIVERSITY

STUDENT HEALTH FORM

STUDENT HEALTH SERVICES • 160 PEARL STREET • FITCHBURG, MA 01420 • 978/665-3216 • 978/665-3643 • FAX: 978/665-3641

Major: _____ Transfer ☐ Yes ☐ No Due Date: _____

ALL FULL-TIME UNDERGRADUATE, AND GRADUATE STUDENTS ARE REQUIRED TO COMPLETE THIS FORM

You should complete page one and two. Your Healthcare Practitioner should verify your medical history and sign the last page of the health forms. This form is the basis of your medical record and remains confidential.

Legal Name: _____ Preferred Name: _____
LAST FIRST MIDDLE

Student ID#: _____ Date of Birth: _____

Gender: ☐ Male ☐ Female ☐ Transgender Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced

Home Telephone: _____ Cell Phone: _____

Home Address (Street or P.O. Box): _____

Town: _____ State: _____ Zip code: _____ Country: _____

PARENT / GUARDIAN

Parent(s)/ Guardian/Partner Name: _____ Relationship: _____

Address: _____ Telephone: _____

Business Address: _____ Telephone: _____

Parent(s) are: ☐ Married ☐ Living with Domestic Partner ☐ Widowed ☐ Divorced ☐ Separated

Alternate responsible person residing at different address from above to be contacted in case of emergency if parent/guardian/spouse/ partner is unavailable.

Name: _____ Phone: _____

Address: _____ Relationship: _____

INSURANCE

Insurance is required for all full time students. Student should carry an insurance card.

Will you be enrolled in the Student Health Insurance plan? ☐ Yes ☐ No

If no, under what insurance will you be covered? _____

Insurance address/phone: _____ Certificate #: _____

Subscriber's Name: _____ Relationship: _____

CONSENT FOR TREATMENT (REQUIRED FOR STUDENTS UNDER 18)
I hereby give consent for my minor child, to receive routine care through the Fitchburg State College Student Health Services.

Signature: _____ Print name: _____
PARENT OR GUARDIAN PARENT OR GUARDIAN

STUDENT HEALTH HISTORY

Check at right of each item. If "yes", explain as appropriate. All items require a "yes" or "no" response.

Explain any "yes" answers at bottom, attach a separate sheet, if necessary.

	Yes	No		Yes	No
Hospitalization (date, reason)			**Have you ever had**		
			Migraines (diagnosed by MD)		
			Epilepsy/convulsions		
Operation (date, reason)			Paralysis or disability		
			Thyroid problems		
			High blood pressure		
			Rheumatic fever		
Serious accident			Heart murmur (diagnosed by MD)		
Serious illness			Mitral valve prolapse		
Emotional problem			Asthma		
Psychiatric treatment			Colitis/ileitis		
Other significant health problems (specify)			Irritable bowel		
Communicable Diseases (give dates)			Hepatitis		
Chicken pox			Kidney disease		
Malaria			Back problems		
Tuberculosis			Recurrent depression		
Other (specify)			Anorexia/Bulimia		
Do you have an Allergy to:			High cholesterol		
Medications			Mono (diagnosed by MD)		
Foods			Diabetes		
Life threatening reaction to insect bites, food, medication ,etc.			Other medical problems		
			Current health problems		
Do you carry epinephrine (Epi-pen)? (explain)			Are you currently in psychiatric counseling?		
Do you currently take: (list at bottom of page)			Do you have a chronic disease? (identify)		
Heart/blood pressure medications			Physical disability (type)		
Insulin			Learning disability		
Antidepressants			Visual impairment (describe)		
Allergy injections			Hearing loss		
ADHD/ADD Medication			Hearing aid		
Birth Control Pills			Crutches, braces, or other prosthesis		
Other (specify)			Loss of paired organ (i.e., one eye, one kidney) (which organ? which side?)		
Lifestyle					
Alcohol (ounces per week)			Are you presently under treatment for any medical problem? (describe)		
Marijuana (times/week)					
Other Illicit Drugs			Medications you expect to be continuing when you come to Fitchburg State (list)		
Do you/have you smoked? Cigarettes per day/years smoking					
Do you diet frequently?					
Do you exercise regularly?					
Do you wear a seatbelt?					
Special diet restrictions (specify)			Have you been immunized with 3 doses of Gardasil?		

NOTE: PROVIDERS—PLEASE REVIEW WITH PATIENT AND PROVIDE (OR ATTACH) ANY PERTINENT MEDICAL INFORMATION.

PHYSICAL EXAMINATION

The FSU athletic trainer will have access to the health forms of students who elect to participate in athletics at Fitchburg State.

I have examined (Name): _____Date: _____and found the following:

Height:_____Weight:_____BMI:_____BP:_____Pulse:_____Respirations:_____

Vision—Without glasses: Right 20/____Left 20/____ With glasses: Right 20/____Left 20/____ Color vision normal: ☐ yes ☐ no

Hearing—Right normal: ☐ yes ☐ no Left normal: ☐ yes ☐ no Hearing aid: ☐ yes ☐ no

Laboratory tests (optional): Glucose: _____HIV: _____ GM% Cholesterol: _____ mg%

Allergies: _____

Medications:_____

Physical Exam (Subjective): _____

_____

_____

ABNORMALITIES

No. System	Yes	No
1. Skin		
2. Eyes		
3. Ears		
4. Nose, throat		
5. Neck, thyroid		
6. Lymphatics		
7. Chest, breasts, lungs		
8. Heart, rate/rhythm		
9. Heart sounds		
10. Abdomen, liver, kidneys, spleen		
11. Hernia		
12. Genitalia		
13. Pelvic		
14. Rectal		
15. Extremities, back, spine		
16. Neurological		
17. Psychological		

List number and describe abnormality

I have known the applicant_____years. The applicant is in ☐ excellent ☐ good ☐ poor health.

The applicant ☐ does ☐ does not have a loss of or seriously impaired function of a paired organ.

The applicant ☐ should ☐ should not have additional ☐ medical ☐ psychological ☐ evaluation ☐ therapy.

The applicant may participate in sports ☐ without a restriction ☐ with the following restrictions ☐ should not participate in sports

Restrictions/Reason for limiting activity or sports:_____

_____

_____

Plan:_____

_____

TUBERCULOSIS RISK QUESTIONNAIRE

Have you had close contact with anyone who was sick with tuberculosis (TB) ☐ yes ☐ no

Were you born in a country that has a high rate of tuberculosis (TB)? PLEASE CIRCLE COUNTRY BELOW (See list of countries below.) ☐ yes ☐ no

Have you traveled or lived for more than one month in a country that has a high rate of tuberculosis (TB)? (See list of countries below.) ☐ yes ☐ no

If the answer to any of the above questions is **YES**, we require that you have a tuberculosis skin test to check for latent tuberculosis infection. If the answer to all of the above questions is **NO**, a tuberculosis skin test should not be done.

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB) (40 PER 1000 CASES)

Afghanistan	Equatorial Guinea	Madagascar	Romania
Algeria	Eritrea	Malawi	Russian Federation
Angola	Ethiopia	Malaysia	Rwanda
Argentina	Fiji	Maldives	Sao Tome &Principe
Armenia	Gabon	Mali	Senegal Sierra
Azerbaijan	Gambia	Marshall Islands	Leone Singapore
Bangladesh	Georgia	Mauritania	Solomon Islands
Belarus	Ghana	Mauritius	Somalia
Benin	Greenland	Micronesia	South Africa
Bhutan	Guatemala	Moldova, Rep.	South Sudan
Bolivia	Guinea	Mongolia	Sri Lanka
Bosnia & Herzegovina	Guinea-Bissau	Morocco	Sudan
Botswana	Guyana	Mozambique	Suriname
Brazil	Haiti	Myanmar	Swaziland
Brunei Darussalam	Honduras	Namibia	Tajikistan
Burkina Faso	India	Nauru	Tanzania, UR
Burundi	Indonesia	Nepal	Thailand
Cambodia	Iraq	Nicaragua	Togo
Cameroon	Kazakhstan	Niger	Turkmenistan
Cape Verde	Kenya	Nigeria	Tuvalu
Central African Republic	Kiribati	N. Mariana Islands	Uganda
Chad	Korea, DPR	Pakistan	Ukraine
China	Korea, Rep.	Palau	Uzbekistan
China, Hong Kong SAR	Kyrgyzstan	Panama	Vanuatu
China, Macao SAR	Lao DPR	Papua New Guinea	Vietnam
Congo & Congo, DR	Latvia	Paraguay	Wallis & Futuna
Cote d'Ivoire	Lesotho	Peru	Yemen
Djibouti	Liberia	Philippines	Zambia
Dominican Republic	Libya	Poland	Zimbabwe
East Timor	Lithuania	Portugal	
Ecuador	Macau	Qatar	

Signature:_____ **Print name:**_____
HEALTHCARE PRACTITIONER HEALTHCARE PRACTITIONER

Healthcare Practitioner's Address:_____

Healthcare Practitioner's Telephone:_____ **Fax:**_____

REQUIRED VACCINES	DATES	MA STATE REQUIREMENTS
MMR *Measles, Mumps and Rubella* -or- **Positive Titer**	#1 ___/_____/_____ #2___/_____/_____ Date:____/_____/____	Two doses: * Minimum of four weeks between dose. * First dose given after first birthday * Positive blood test for immunity
Tdap *Tetanus, Diphtheria, Pertussis*	Tdap:___/_____/_____	One dose
Meningococcal: MenACWY (meningitis vaccine) **Signed Waiver**	# 1-date:___/____/____ # 2-date:___/____/____ Date:____/____/_____	* One dose at age 16 or older for all incoming students age 21 or younger * Second dose highly recommended Signed waiver form
Varicella (*chicken pox*) -or- **Positive titer** -or- **History of disease**	# 1____/_____/____ # 2___/_____/_____ Positive titer date:____/____/____ History of disease date:___/___/___	*First dose given after first birthday * Minimum of four weeks between doses *Positive blood test for immunity * History of disease
Hepatitis B -or- **Hepatitis A and B combined** -or- **Positive titer**	# 1 ___/____/____ # 2____/____/____ # 3____/____/____ Positive HBsAg titer date:____/____/____	* Three doses Typically scheduled at zero, one and –four to six months Positive blood test for immunity

HIGHLY RECOMMENDED IMMUNIZATIONS

Meningococcal Group B * MenB-4C -or- * MenB-FHbp	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ #3___/___/___	Two doses at least one month apart -or- Three doses at zero, two and six months
Second dose of Meningococcal: MenACWY	Date:___/___/___	First dose or waiver required; second dose highly recommended
Human Papillomavirus (HPV)	#1___/___/___ #2___/___/___ #3___/___/___	Three doses Typical schedule at zero, two and six months
Hepatitis A	#1 ___/___/___ #2___/___/___	Two does at least six months apart
Other Vaccines: *** Influenza vaccine**	Date: ___/___/___	Prevention and Control of Seasonal Influenza