BECKER COLLEGE

Student Health Record

Part 1

Please print:

Name: ____ Date of Birth __________

(last) (first) (middle)

Date of Entry: ___/___ Academic Major: ________________________________

mo / yr

Home Address: ____

Street/P.O. Box City/ Town State Zip

Home Telephone: __________________ Student Cell #: ____________________

Sports Team Participation? If so which one(s):

Emergency Contact Information:

In the event of an emergency, please contact the following:

Name: _______________________________Relationship: ________________________

Address: ____

Home phone: ______________________ Business Phone: ______________________

Cell phone: ____

Health Insurance Information:

***NOTE* Massachusetts law mandates that all Massachusetts residents and all out of state students carrying 9 or more credits be enrolled in a health insurance plan.**

Do you plan to enroll in the Student Health Insurance plan? ☐ Yes ☐ No*

***If no**, please provide the following.

Insurance company: _________________________ Policy # ______________________

Subscriber: ____________________________ Relationship: _______________________

NOTE: If you are not using the School's Medical Insurance plan you will need to remove your student from automatic enrollment to get credit/deduction. (Must be done on line, retain confirmation #)

*****Student needs to have health card with them @ school.**

Consent for treatment:

I hereby give consent for _________________________ to receive routine care through Health Services. In the event of an emergency, I give permission to Health Services to secure appropriate treatment, including transport to a local hospital if necessary. **Your signature also allows Health Services to release any PERTINENT medical information** (i.e. allergies, immunization status, and special medical conditions) to specific disciplines within the College. (I.e. Registrar, professors, &/or coaches. ****Nursing Students** please be advised that your signature above will allow the release of your health & immunization information to clinical sites as deemed necessary for clinical clearance.)

Parent/ Guardian Signature ____

(Required for students under age 18) Relationship: ______________________________

Student Signature: ____

(Required for students age 18 and over)

Becker College

Student Health Record

Part 2

Student Name ____ Date of Birth _____________

____________PERSONAL MEDICAL HISTORY –TO BE COMPLETED BY STUDENT____________

Allergies: ( ) food ( ) medication ( ) other epi-pen required? Yes or No

Please Specify/Describe Allergy____

Medications: Please **list *all* medications** that you are presently taking. (Include vitamins, prescription & non-prescription.)

____

____

Personal Medical History: Circle all that apply: current or past conditions (list dates & specific information below)

- Anemia
- Anorexia Nervosa
- Anxiety Disorder
- Asthma
- Bulimia
- Chicken Pox
- Colitis/Ileitis
- Diabetes
- Depression
- Eye Disease
- Ear Disease
- GI Issues
- Gyn Problem
- Head Injury/Concuss
- Hearing Loss
- Heart Disease/Murmur
- Hernia
- High Blood Pressure
- Jaundice/Hepatitis
- Joint Disease
- Migraines
- Mononucleosis
- Rheumatic Fever
- Seizure Disorder
- Sinus Infection
- Skin Condition
- Testicular Disease/Problem
- Thyroid Disease
- Tobacco Use
- Urinary Tract Disease
- Weakness/Paralysis
- Weight loss/gain
- Other: ________________

Additional Information on Above:

____

____

Operations/Hospitalizations/Accidents: (Provide details including dates, diagnoses, surgeries, etc.)____

____

PHYSICAL EXAMINATION - TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

This student has been accepted for admission to Becker College. All health information is confidential and will not affect his/her enrollment status. Becker College requires a physical exam within 12 months prior to admission.

DATE of PHYSICAL EXAM:______________

Weight _______ Height _______ BP __________ Pulse ______ Glasses Contacts Vision (R) _______ Vision (L)_______

Appearance
Eyes
Ears
Nose
Throat
Heart
Pulse(s)
Lungs
Abdomen
Hernia
Skin

Musculoskeletal
Neck
Back
Shoulders
Elbow/Forearm
Wrists
Hands/Fingers
Hips/Thighs
Knees
Legs/Ankles
Feet/Toes

ANY PHYSICAL LIMITATIONS OR RESTRICTIONS? specify)___________________________

Cleared to participate in sports? YES or NO Any Restrictions?____________________________

Health Care Provider's signature ________________________________Date____________________

Provider's Name (print)____

Address____________________________________City________________State_________ZIP:_____

Telephone #_________________________________Office Fax # ________________________________

Becker College

Student Health Record

Part 3

Name: _______________________________ Date of Birth: ________________

(To be completed & signed by Physician or designated office representative.)

Immunizations required by Massachusetts Dept of Public Health:

Measles/Mumps/Rubella (2 doses) **mo/day/year**

MMR (first dose at 12 months or later) #1___/___/___

MMR (second dose after age 5) #2___/___/___

OR

Measles (2 doses required) #1___/___/___ #2___/___/___

Mumps___/___/___

Rubella ___/___/___

OR

MMR (+)titres (attach copy of lab report)

(3 separate titers are required; rubeola, mumps & rubella. Each must be immune, or provide booster information.)

****

Tetanus-Diphtheria (Td) or (Tdap)

(Booster must be within last 10 years)

Td___/___/___ **OR** **Tdap**___/___/___

****

Tuberculosis Risk Assessment (see next page)**

****All Animal Studies are required to have a PPD skin test before entry. **Nursing Students are required 2 Step PPD skin testing for clinical entry, then annual updates. (Note: 2 Step PPD is a skin test series: 2 tests w/in 1 year but not closer than 2weeks apart.)**

****

Hepatitis B -3 dose series

#1 ___/___/___ #2 ___/___/___ #3 ___/___/___

OR

Hepatitis B - 2-dose formulation (10mcg Recombivax or 10mcg Merck)

#1___/___/___ #2___/___/___

OR

Hepatitis B Antibody titre **(attach lab report)**

****

Meningococcal Vaccine (or attach signed waiver) ___/___/___

(Must be given w/in 5 years of entry)

****

Varicella (chicken pox)** **History: yes or no Approx Date: mo/yr __/__**

****Nursing Students are required to provide proof of Varicella immunity through labwork (Attach copy of lab report on student's record.) OR Documentation of 2 shot series.**

Varicella Vaccine: #1___/___/___ #2___/___/___

Health Care Provider's signature______________________________Date____________________

Provider's Name (print)____

Telephone #_________________________________Office Fax # ___________________________

Becker College

Student Health Record

Part 4

Name: ________________________________ Date of Birth: _________________

TUBERCULOSIS RISK QUESTIONNAIRE- For you and your health care provider

1. Have you ever had a positive tuberculosis skin test? YES ☐* NO ☐

*If history of a **POSITIVE TUBERCULIN SKIN TEST** in the past, the test should not be repeated. **Go to Section B**

2. To your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB)? YES ☐ NO ☐

3. Were you born in one of the countries listed below? YES ☐ NO ☐

4. Have you traveled or lived for more than one month in any of the countries listed below? YES ☐ NO ☐

Health Care Provider: If the student/patient answered "yes" to any of questions #2-4 ; Becker requires a tuberculin skin test.

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

± World Health Organization, Global Tuberculosis Control: Estimated burden of TB in 2005 Http://www.who.int/tb/publications/global_report/2007/xls/global.xls

A. Secondary Screening: TUBERCULIN SKIN TEST (Mantoux/Intermediate PPD*) required if answered yes to any of questions #2-4. **Multiple puncture tests (e.g., Tine or Monovac) is NOT accepted.*

Plant date: _____ / _____ / ______ **Signature**______________________	**Read date*:** _____ / _____ / ______ * 48-72 hours after administration **Signature**______________________________	**Result*** ______ **mm of induration** * If no induration, mark "0"

B. Tertiary Screening: If Tuberculin Skin Test is POSITIVE (now, or by history) the following are required:

1.	**Date of Positive PPD:** ______ / _____ / ______
2.	**Chest X-ray: (w/in 5 years of entry)** ☐ Normal ☐ Abnormal **Date:** ______ / ______ / ______ **(attach report, NOT the X-ray)** (Describe) ______________________________
3.	**Clinical Evaluation:** ☐ Normal ☐ Abnormal (Describe:)
4.	**Treatment:** ☐ No ☐ Yes Drug, dose, frequency and dates: ______________________________

Health Care Provider's signature______________________________Date____________________

Provider's Name (print)____