Medical History, Physical Examination, and Immunization Form
American International College Dexter Health Services

1000 State Street, Box 55, Springfield, MA 01109 | Phone 413-205-3248 | Fax 413-205-3512

I will be a: ☐ First Year Undergrad ☐ Transfer ☐ First Year Grad ☐ Returning Athlete

STUDENTS please complete demographic and health history before going to your health care provider.

NAME LAST FIRST MIDDLE				Gender ☐ M ☐ F ☐ Other _____
DATE OF BIRTH (MM-DD-YY)	CELL PHONE		HOME PHONE	
ADDRESS – STREET	CITY	STATE	ZIP	COUNTRY
EMERGENCY CONTACT NAME RELATIONSHIP		HOME PHONE	WORK PHONE	CELL PHONE

LIST ALLERGIES:	LIST PRESCRIPTIONS OR OVER-THE-COUNTER MEDICINES (include dose):

PERSONAL HISTORY*:* Please check any that pertain to you. Explain positives in space provided.

Anxiety		Diabetes		Hernia		Seizures	
Asthma		Ear trouble/Hearing loss		High Blood Pressure		Sickle cell trait	
ADD/ADHD		Eating disorder		High cholesterol		Sinus problems	
Cancer		Eye trouble/Visual loss		Intestinal/Stomach trouble		Spleen (Surgical removal)	
Chest pain		Fractures (including stress)		Joint injury (sprain/dislocation)		Syncope/Fainting	
Concussion/Head injury		Genetic disorder		Kidney disease		Thyroid disease	
Convulsive disorder		Headaches (recurrent)		Mononucleosis		Tobacco use	
Other health conditions:							
Surgeries:							

FAMILY MEDICAL HISTORY: Please list medical conditions, diseases, cancers or severe illness if any:

Father		Brothers	
Mother		Sisters	

You must answer the following Tuberculosis risk questions.

Have you ever had close contact with anyone sick with TB? ☐Yes ☐No

Were you born in or lived for more than 1 month in any foreign country? ☐Yes ☐No

If you answered ***YES*** to either of the TB questions above, you will need to provide proof of a negative TB blood test or chest x-ray.

HEALTH SCIENCE STUDENTS must have two-step Tuberculin Skin Test (Mantoux) #1.) Date administered: ___/___/___ Date read: ____/____/____ Results: ___ mm induration #2.) Date administered: ___/___/___ Date read: ____/____/____ Results: ___ mm induration **or** TB blood test/Quantiferon Gold Date: __/___/___ Results: _____

Licensed provider signature _____

ATHLETES must have sickle cell trait screening/solubility test. Please provide a copy of athlete's newborn screen or recent blood test results:

Date: ___/___/___ Results: _____ Licensed provider signature _____

CONSENT FOR TREATMENT In case of serious illness or accident, I give AIC Dexter Health Services or its representative(s) permission to secure medical and/or surgical care deemed necessary for my good health. I authorize Health Services to perform medical care and immunizations as deemed necessary by licensed personnel. Also, I have read the Notice of Privacy Practices (HIPAA) disclosing how AIC Dexter Health Services may use and disclose my protected health information.

_____

Student Signature (parent or legal guardian if student is under 18 on first day of classes) Date

Student's Name:_____ **Date of Birth:** _____

PHYSICAL EXAMINATION

(Must be completed by a licensed MD, DO, NP, PA)

Height _____ Weight _____ BP _____ Pulse _____ Vision R 20/ ____L 20/ ___ Corrected: Y N

	√ Normal	Abnormal (explain)
Skin		
Eyes, Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal/Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological, Psychiatric		
Other Significant Abnormalities		

Is there any reason this student should not participate in sports? Specify ☐Yes ☐No

Do you have any recommendations regarding the care of this student? Specify ☐Yes ☐No

Is the patient now under treatment for emotional or psychological conditions? Specify ☐Yes ☐No

Please complete the following or attach a copy of the Immunization Records or Laboratory Evidence of Immunity (Positive Titers).

Tdap (Tetanus-Diphtheria-Pertussis) Month/Day/Yr _____

Td or Tdap if ≥ 10 years since Tdap Month/Day/Yr _____

MMR (2 doses) Vaccine #1 (given on or after the 1st birthday) Month/Day/Yr _____

MMR Vaccine #2 (given ≥ 28 days after first dose) Month/Day/Yr _____

Hepatitis B (3 doses) Vaccine #1 Month/Day/Yr _____

Hepatitis B Vaccine #2 Month/Day/Yr _____

Hepatitis B Vaccine #3 Month/Day/Yr _____

Varicella (2 doses) Vaccine #1 (given on or after the 1st birthday) Month/Day/Yr _____

Varicella Vaccine #2 (given ≥ 28 days after first dose) Month/Day/Yr _____

Meningococcal (MenACWY) (*must have been received on or after the student's 16th birthday)* Month/Day/Yr _____

Meningococcal B Vaccine (strongly recommended) Month/Day/Yr _____

COVID-19 Vaccine(s): Month/Day/Yr _____

Month/Day/Yr _____

COVID-19 Booster Dose (strongly recommended) Month/Day/Yr _____

Provider's Name: _____ ☐MD ☐DO ☐NP ☐PA Facility's Address: _____

Signature _____ Phone _____ Fax_____ Date of Examination _____