Medical History Form

American International College | Dexter Health Services | 1000 State Street, Box 55, Springfield, MA 01109 | Phone 413-205-3248 | Fax 413-205-3512

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:							
List past Surgeries/surgical procedures:							

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

Father		Brothers	
Mother		Sisters	

You must complete the following Tuberculosis Risk Assessment:

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

☐Yes ☐No Were you born in or lived in a country with an elevated TB rate? (includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe)

☐Yes ☐No Are you immunosuppressed (current or planned)? (includes HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)

If you answered ***YES*** to any of the TB questions above, you must provide proof of a negative IGRA TB blood test or treatment for latent TB.

STUDENT-ATHLETES must have sickle cell trait screening/solubility test. Please provide a copy of athlete's newborn screen or Hemoglobin S blood test results (Sickledex or hemoglobin solubility test). Attach results.
Date: ____/____/_____ Result: _____________ Licensed provider name & signature _______________________________________

HEALTH SCIENCE STUDENTS must have two-step Tuberculin Skin Test (Mantoux). Attach results.
Step #1.) Date administered: ___/___/___ Date read: ____/____/____ Results: _____ mm induration
Step #2.) (placed 7-21 days after the first TST) Date administered: ___/___/___ Date read: ____/____/____ Results: _____ mm induration
or QuantiFERON-TB Gold Date: ___/___/___ Result: _______ Licensed provider name & signature __________________________

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

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Student Signature (parent or legal guardian if student is under 18) Date

Upload your completed forms to your AIC Patient Portal by visiting https://aic.medicatconnect.com/

Physical Examination and Immunization Form

To be completed by a licensed health care provider

Student's Name: _______________________________________ **Date of Birth**: _______________________________

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 Student's Immunization Records or Laboratory Evidence of Immunity:

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 Vaccines & Booster (strongly recommended) *(List manufacturer)* Month/Day/Yr __________________

Month/Day/Yr __________________

Month/Day/Yr __________________

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

Provider's Signature: ______________________ Phone ____________________ **Date of Examination** _________________