

Medical History, Physical Examination, and Immunization Form

American International College

Dexter Health Services

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

Please return to Health Services prior to the start of classes.

Physical should be done within the last year prior to the first day of classes. Athletes no earlier than 6 months prior.

I will be: 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	I identify my gender as <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other _____	
DATE OF BIRTH (MM-DD-YY)		CELL PHONE	HOME PHONE	
ADDRESS – HOME		CITY	STATE	ZIP COUNTRY
EMERGENCY CONTACT NAME	RELATIONSHIP	HOME PHONE	WORK PHONE	CELL PHONE
ANY ALLERGIES?	PRESCRIPTIONS OR OVER THE COUNTER MEDICINES YOU ARE TAKING (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 or surgeries				

FAMILY HISTORY: Please state any serious illnesses/injuries or if deceased cause.

Father		Brothers	
Mother		Sister	

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 **please print out the TB form and bring it to your physical** appointment as you **will** need a TB skin test.

<p>HEALTH SCIENCE STUDENTS must have two-step Tuberculin Skin Test (Mantoux) 1.) Date read: ___/___/___</p> <p>Results: ___ mm induration 2.) Date read: ___/___/___ Results: ___ mm induration or TB Gold blood test Date: ___/___/___</p> <p>Results: ___ mm Licensed provider signature _____</p>

<p>ATHLETES must have sickle cell blood test. Include any documentation.</p> <p>Copy of athlete's newborn sickle cell testing result or recent screening test results.</p> <p>Date: ___/___/___ Results: _____ Licensed provider signature _____</p>

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 if student is under 18 on day 1 of classes)

Date

Name _____

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)

	√ 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

American International College requires all the following immunizations whether a resident or commuter unless otherwise stated.

Tetanus-Diphtheria Acellular Pertussis Month/Day/Yr _____

Td if Tdap greater than 10 years Month/Day/Yr _____

MMR Vaccine #1(on or after the first birthday) Month/Day/Yr _____

MMR Vaccine #2 (at least 1 month after the first) Month/Day/Yr _____

Hepatitis B Vaccine #1 Month/Day/Yr _____

Hepatitis B Vaccine #2 (at least 30 days after the first dose) Month/Day/Yr _____

Hepatitis B Vaccine #3 (5 months after the second dose) Month/Day/Yr _____

Varicella Vaccine #1(at or after 12 months of age) Month/Day/Yr _____

Varicella Vaccine #2 (given > 4 weeks after the first dose) Month/Day/Yr _____

Meningococcal Vaccine (*must be within 5 years of the start of classes*) Month/Day/Yr _____

*If proof of immunization for a measles, mumps, rubella, Hepatitis B or Varicella is not available a **Blood titer immunity proven by laboratory confirmation will be accepted. Please attach the lab results.***

Print or Stamp

Name _____ Address _____

Signature _____ Phone _____ Fax _____ Date of Examination _____

MD DO NP PA