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WASHINGTON COLLEGE

Student Health and Counseling Health Form for International Students and Domestic Students Living Abroad

Queen Anne Building
300 Washington Avenue
Chestertown, MD 21620

410-778-7261 Fax 410-810-7101
health_services@washcoll.edu

Please complete this form and return it to the Health Service. Forms should be returned by July 15, for students entering in the fall, and by January 1st for students entering in the spring. **This form must be completed and the immunization requirements met before you will be allowed to register.** All information contained in this form will be held in confidence and will not be released to anyone on or off campus without your knowledge and consent.

Student's Name____Student's Cell #______________________________

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY:

Father/Guardian____
Home Address____
____
Country____
Place of employment____
Work #____
Home #____
Cell #____

Mother/Guardian____
Home Address____
____
Country ____
Place of employment____
Work #____
Home #____
Cell #____

Consent for Treatment/Hospital Release

The undersigned herewith:
A. Grants permission to Washington College Health, Counseling, and Sports Medicine Services to provide medical care including administration of treatments and medications as necessary. This includes emergency room visits, lab work, x-rays, etc., which may need to be done at Chester River Hospital Center.

B. Authorizes the Student Health Services and Sports Medicine Services to exchange and release information to each other that may impact on my athletic participation. Understands that this information includes but is not limited to this pre-season questionnaire/screening and Washington College Health Services health evaluation, immunization record, consent for treatment and questionnaire.

C. Understands that I must refrain from participation while ill or injured, whether receiving medical treatment or not, and during medical treatment until discharged from treatment or given permission by the College Nurse Practitioner or College Physician to restart participation while continuing treatment.

E. Acknowledge that the Washington College Health Service acts as your primary health care provider while you are attending Washington College as a student. Authorize the Washington College Health Service and Chester River Hospital Center to exchange and release to each other medical and insurance information about you for treatment and to ensure follow-up care. This form will remain valid until you graduate from Washington college or cease to be enrolled at the college, whichever is earlier.

F. Certifies that the answers to the questions on this Health Record are correct and true.
*Parent/Guardian must co-sign if student is under age 18.

______________________________________ ______________________
Student Signature Date

______________________________________ ______________________
Parent/Guardian Signature if student is a minor Date

PHYSICAL ASSESSMENT *To be completed by your health care provider.

Student's Last Name First Middle Date of Birth Sex Race

LIST DRUG & OTHER ALLERGIES:______________________________

____

Latex allergy: Yes__________ No ____________

Pulse______________________Respirations_________________________BP________________________Height____________Weight____________

EXAM	Normal ✓	Abnormal or additional elements
General	☐	
Eyes	☐	
Ears	☐	
NMT	☐	
Neck	☐	
Chest	☐	
Cardiovasc.	☐	
Breast	☐	
Abdomen	☐	
GU/GYN	☐	
Back	☐	
Musc.-skel./ext.	☐	
Skin	☐	
Neuro	☐	

Please list any prior surgeries, include dates: ______________________________

____

Is this student under treatment for any medical or emotional condition? If yes, explain. ______________________________

____

Limitations or Special Condition (please include any special dietary needs): ______________________________

____

Current Medications (please include dosage): ______________________________

____

Intercollegiate Athletics Participation Assessment:

_________Full Participation

_________Limited Participation(describe limitations, restrictions, time frame and if follow -up evaluation needed.)

_________Participation Contraindicated (list reasons).

HEALTH CARE PROVIDER STATEMENT:

This student has been evaluated and found to be in good health and able to participate in highly competitive intercollegiate athletics unless stipulated in assessment above.

______________________________ ______________________________

Signature of physician/nurse practitioner Date

Provider's Name (please print)______________________________

Providers Address/phone #______________________________

______________________________Provider's Fax #______________________________

IMMUNIZATION RECORD FOR INTERNATIONAL STUDENTS

Part I: To be completed by student. Please print.

Name ____
Last Name First Name Middle Name

Date of Birth ________/________/________ Social Security # ____________________ Phone (________) - ____________________
Month Day Year

Part II. To be completed and signed by a Health Care Provider (Include month, day, year and translate all lab work and results in English)

REQUIRED

A. TUBERCULOSIS (All students must complete this section. Students are not allowed to register if information is incomplete. No exceptions!)

1. Chest x-ray within the last six months. You must send a copy of the x-ray report. Please do not send the x-ray.

   Date of the x-ray ________/________/________ (Month Day Year) Result: Negative__________ Positive__________ **(If positive, please include treatment plan.)**

2. If you have had the BCG vaccine, please check here and include date given: yes __________ no __________ Date ________/________/________ (Month Day Year)

B. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations…………………………….________/________/________ (Month Day Year)
2. Received tetanus-diphtheria booster **within the last 10 years**…………………………….....________/________/________ (Month Day Year)

   or Tdap booster (recommended for ages 11-64)…………………………………………..…________/________/________ (Month Day Year)

C. M.M.R. (Measles, Mumps, Rubella)

1. Dose 1 - Immunized at 12 months or after and before 5 years…………………………...#1 ________/________/________ (Month Day Year)
2. Dose 2 - Immunized at 5 years or later (at least 28 days after first dose)………………...#2 ________/________/________ (Month Day Year)

D. POLIO **please circle vaccine type: Oral Inactivated E-IPV**

Completed primary series of polio immunization ________/________/________ (Month Day Year) Last booster ________/________/________ (Month Day Year)

E. HEPATITIS B

1. Dose #1 ________/________/________ (Month Day Year) Dose #2 ________/________/________ (Month Day Year) Dose #3 ________/________/________ (Month Day Year)
2. Surface antibody Date ________/________/________ (Month Day Year) Result: Reactive _______ Non-reactive _______

F. MENINGITIS VACCINE (Required by Maryland law for all college students)

1. Type of vaccine ____________________________ Date ________/________/________ (Month Day Year)
2. Booster required if original dose given before age 16 Date ________/________/________ (Month Day Year)

G. VARICELLA

1. History of the disease? Yes ________ No _______ Varicella antibody ________/________/________ (Month Day Year) Result: Reactive _____ Non-reactive _____
2. Immunization Dose #1 ________/________/________ (Month Day Year) Dose #2 ________/________/________ (Month Day Year)

RECOMMENDED

H. HEPATITIS A

1. Immunization (hepatitis A) Dose #1 ________/________/________ (Month Day Year) Dose #2 ________/________/________ (Month Day Year)
2. Immunization (Combined hepatitis A and B vaccine)

   Dose #1 ________/________/________ (Month Day Year) Dose #2 ________/________/________ (Month Day Year) Dose #3 ________/________/________ (Month Day Year)

I. HUMAN PAPILLOMAVIRUS VACCINE (HPV4)

Dose #1 ________/________/________ (Month Day Year) Dose #2 ________/________/________ (Month Day Year) Dose #3 ________/________/________ (Month Day Year)

J. Please list other immunizations you have had and the dates given. Please include malaria prevention if taking it.

Immunization ____________________________ Date ______/______/______ Immunization: ____________________________ Date ______/______/______

Health Care Provider ____ (Signature) **Date** ________/________/________ (Month Day Year)

Address ____ **Phone** ____________________

Name____**Date**____

PAST HISTORY: Please indicate problems you have now or may have had in the past. Please comment about any positive answers on a separate sheet of paper. This information is used solely as an aid to provide necessary health care while you are a student. It is considered confidential information and can not be released to anyone without your permission.

Abdominal pain	yes	no
AIDS, ARC, or positive HIV	yes	no
Alcohol Problem	yes	no
Allergies (seasonal)	yes	no
Anemia/Easy Bruising or Bleeding	yes	no
Anorexia	yes	no
Anxiety (frequent)/Nervousness	yes	no
Asthma/Wheezing	yes	no
Back Problems	yes	no
Bee Sting Reaction	yes	no
Bladder Infection (Cystitis)	yes	no
Bleeding Trait (Sickle Cell)	yes	no
Bronchitis	yes	no
Cancer (location_______________)	yes	no
Chicken Pox	yes	no
Contacts/Glasses/Visual Problems	yes	no
Dental Problems	yes	no
Depression	yes	no
Diabetes	yes	no
Dizziness/Vertigo	yes	no
Drug dependency	yes	no
Dyslexia	yes	no
Ear Problems	yes	no
Eating Disorder	yes	no
Eczema	yes	no
Emotional or mental health issues	yes	no
Health Issues	yes	no
Epilepsy	yes	no
Eye Problems	yes	no
Fainting/Dizziness	yes	no
Fibrocystic Breast Disease	yes	no
Food Intolerance	yes	no
Gall Bladder Disease	yes	no
Heat Stroke or Exhaustion	yes	no
Headaches (frequent)	yes	no
Stress / Migraine	yes	no
Hearing Loss	yes	no
Heart Problems	yes	no
Palpitations	yes	no
Rheumatic Heart	yes	no
Heart Murmur	yes	no
Chest pain with exercise	yes	no
Hepatitis	yes	no
Hernia	yes	no
High Blood Pressure	yes	no
Hypoglycemia	yes	no
Irritable Bowel Disorder	yes	no
Kidney problems	yes	no
Lyme Disease	yes	no
Marfan Syndrome	yes	no
Menstrual problems	yes	no
Mononucleosis – (give dat___)	yes	no
Nosebleeds	yes	no
Obesity (>20 lbs. overweight)	yes	no
Organ (loss of paired organ)	yes	no
Ovarian cyst	yes	no
Peptic Ulcer (gastric or duodenal	yes	no
Phlebitis	yes	no
Pinched Nerve	yes	no
Pneumonia	yes	no
Rheumatic Fever	yes	no
Rheumatoid Arthritis	yes	no
Seizures or Convulsions	yes	no
Sinus Problems	yes	no
Stomach Problems	yes	no
Suicide Attempt	yes	no
Thyroid Problem	yes	no
Tuberculosis	yes	no
Urinary Problems	yes	no
Weight Loss or Gain	yes	no

Do you smoke cigarettes? yes no

How many last month? ______________________

How long have you smoked? _________________

Do you use smokeless tobacco? yes no

How long?

Do you drink alcohol? yes no

Approximate number of drinks per occasion: __________

Number of drinking occasions per week: __________

Drug use (past or present) yes no

Have you ever been hospitalized yes no

Please list reason and dates

____

____

____

____

____

____

Other problems not listed:

____

____

____

____

Have you ever had:

Any broken bones? yes no

specify:________________________

Dislocations? yes no

specify:________________________

Pain or swelling of muscle or joint?	Yes	no
Injury to tendons, ligaments or cartilage	yes	no
AC separation or shoulder injury	yes	no
Blow to the head that knocked you out?	Yes	no
Concussion? How many?_______	Yes	no
Injury to the neck or back?	Yes	no
Spinal Fusion?	Yes	no
Burner (hand or arm discomfort)	yes	no
Marfan Syndrome?	Yes	no

***If you require special accommodations please contact this office asap.**

Family History:

Have any of your relatives had:

Cancer	yes	no
Diabetes	yes	no
Epilepsy	yes	no
Have Sickle Cell Trait	yes	no
Heart Disease	yes	no
High Blood Pressure	yes	no
Kidney Disease	yes	no
Tuberculosis	yes	no

	Age	State of Health	Occupation	Age at Death	Cause of Death	Date of Death
Father						
Mother						
Brothers						
Sisters						