COMPLETE YOUR HEALTH FORMS

MEDICAL HISTORY, PHYSICAL EXAMINATION, AND IMMUNIZATION FORM

Completed forms should be mailed, faxed (413.205.3512), or dropped off any time 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.

Last Name	First Name	Middle	I identify my gender as ☐ M ☐ F ☐ Other:	
Date of Birth (MM-DD-YY)		Cell Phone		Home Phone
Home Address	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.

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

HEALTH SCIENCE STUDENTS must have two-step Tuberculin Skin Test (Mantoux) 1.) Date read: ____/____/____ (mm/dd/yyyy)

Results: _____ mm induration 2.) Date read: ____/____/____ (mm/dd/yyyy) Results: _____ mm induration or TB Gold blood test Date: ____/____/____ (mm/dd/yyyy) Results: _____ mm Licensed provider signature:_____

ATHLETES must have sickle cell blood test. Include any documentation.

Copy of athlete's newborn sickle cell testing result or recent screening test results.

Date: ____/____/____ (mm/dd/yyyy) 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 if student is under 18 on day 1 of classes) Date

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PHYSICAL EXAMINATION

MUST BE COMPLETED BY A LICENSED MD, DO, NP, PA

Name _____

Height _____ Weight _____ BP _____ Pulse _____ Vision R 20/_____ L 20/_____ Corrected: ☐ Yes ☐ No

	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 A Vaccine (***must be within 5 years of the start of classes***) Month / Day / Yr ___/___/___
Meningococcal B Vaccine (strongly recommended) 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 ☐ MD ☐ DO ☐ NP ☐ PA Phone Fax Date of Examination