



WPI
 100 INSTITUTE ROAD
 WORCESTER, MA 01609
 PHONE: 508-831-5520
 FAX: 508-831-5953

HEALTH SERVICES

FOR WPI STAFF USE ONLY
 ? **COMPLETE:** Date: _____

ALLERGIES:

OTHER:

MMR #1? #2? Titers?
 Hepatitis B #1? #2? #3? Titer?
 Td? Tdap? Varicella?
 Meningitis: Vaccine? Waiver?
 PPD: N/A? Neg? Pos?
 Chest X-ray? INH?
 Athletic Clearance? Exemption?

◆ **PLEASE NOTE** ◆

To avoid a registration hold, return the completed Health Report by:

DEADLINES

Fall Semester July 12

If enrolling after the deadline, your Health Report must be submitted by the end of the first week of classes.

NAME: _____ **DATE OF BIRTH:** _____
Last First MI Month Day Year

PERMANENT ADDRESS: _____ **SOC. SEC #:** _____
Street

City State Zip Country **BIRTHPLACE:** _____
Country

HOME PHONE : ____ (____) _____ **CELL PHONE :** ____ (____) _____

EMAIL: _____ **INSURANCE:** _____ **ID#** _____ **GROUP#** _____ **SUBSCRIBER:** _____

If transferring, college(s) attended: _____ Dates attended: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____

Address: _____
Street City State Zip Country

Home or Cell Phone: ____ (____) _____ Business Phone: ____ (____) _____
Country Code if International or Area Code Country Code if International or Area Code

PRIMARY CARE PROVIDER: _____
Name Phone

Medical Consent Form

Student Signature (if 18 or older) _____ Date _____

PARENT/GUARDIAN SIGNATURE REQUIRED if student is a minor (under 18 years of age)

I hereby grant permission to WPI Health Services or authorized representatives, to provide such medical care as my daughter or son _____, may require while she/he is a student at WPI, including examinations, treatment, immunizations, etc. This also includes referral to outside providers, local hospitals, hospitalization, anesthesia and/or surgery should it be necessary in the event of serious illness or injury and I am not able to be reached.

Name of Parent/Guardian (print) _____ Signature: _____ Date: _____

CONFIDENTIAL MEDICAL HISTORY

FAMILY HISTORY

	Present Age or Age at Death	State of Health or Cause of Death (good, fair or poor)	Have any of your immediate relatives had any of the following:		
			No	Yes	Relationship
Father			Alcohol/Drug Problem		
Mother			Cancer		
Brothers			Diabetes		
			Heart Disease		
Sisters			High Blood Pressure		
			Kidney Disease		
Spouse			Neurologic Disease		
Children			Mental Illness		
			Tuberculosis		

PERSONAL HISTORY Do you have now or have you ever had: (check all that apply)

- | | | | |
|---------------------------------------|------------------------------|--|--------------------------|
| 1. Anemia | 10. Deaf/hearing impairment | 19. Impaired mobility/paralysis | 28. Pneumothorax |
| 2. Anorexia Nervosa/Bulimia | 11. Depression | 20. Kidney disease/stones | 29. Seizure disorder |
| 3. Appendectomy | 12. Diabetes | 21. Learning disability/ ADD/ADHD | 30. Sickle cell disease |
| 4. Arthritis | 13. Emotional/mental illness | 22. Loss of paired organ (eye, kidney) | 31. Thyroid disease |
| 5. Asthma | 14. Heart disease/problem | 23. Malaria | 32. Positive TB test |
| 6. Blind/Visual impairment | 15. Hepatitis (Type ____) | 24. Migraines/chronic headaches | 33. Tuberculosis disease |
| 7. Cancer/malignancy
problem | 16. High blood pressure | 25. Mononucleosis | 34. Ulcer/stomach |
| 8. Chickenpox
(frequent/recurrent) | 17. High cholesterol | 26. Neuromuscular disease | 35. UTIs |
| 9. Crohn's/Ulcerative Colitis/IBS | 18. HIV infection/disease | 27. Phlebitis/deep vein clot | 36. Other _____ |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates) _____

GYNECOLOGICAL HISTORY (Check all that apply):

Date of last PAP test _____ Result: _____ Have you ever had an abnormal PAP smear? _____ Colposcopy? _____ Date _____

Irregular periods/no periods Pelvic inflammatory disease (PID) Other sexually transmitted infection (STI/STD) _____

Polycystic Ovary Syndrome (PCOS) Genital herpes (HSV) Use CONTRACEPTION Pill Other _____

Breast lumps/fibrocystic disease Genital warts (HPV) Pregnancy (live births) # _____ Abortion/Miscarriage # _____

INPATIENT HOSPITALIZATIONS: Please list all medical and/or psychiatric hospitalizations with dates and diagnoses:

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medications, antidepressants, etc.

ALLERGIES: None known Yes

If yes, please specify, including medications, insect venom, foods, etc. : _____ Type of reaction: _____

IMMUNIZATION FORM

Phone: 508-831-5520●

Fax 508-831-5953

WPI

Health Services

PART I: (to be completed by student)

NAME : (print)	DATE OF BIRTH:	SS #:
COUNTRY OF BIRTH:	If not born in USA, year entered the country: _____	

PART II: REQUIRED IMMUNIZATIONS (to be completed by a medical provider)

★ The following immunizations are required by Massachusetts Law. All dates must include month/day/year. If documentation of immunization is not available or if a blood test indicates that you are NOT immune, you must be re-immunized. Attached documents in a language other than English **must be translated into English** by the health care provider.

<p>★HEPATITIS B (Three doses required)</p> <p>Dose 1: ____/____/____</p> <p>Dose 2: ____/____/____ (Must be at least 1 month after #1)</p> <p>Dose 3: ____/____/____ (Must be at least 2 months after #2 and 4 months after #1)</p> <p>OR Lab test proving immunity (attach lab report)</p> <p>Immune – Titer value _____ Date: ____/____/____</p>	<p>★MMR (Measles, Mumps, Rubella)</p> <p>Two doses required, at least one month apart, after 12 months of age</p> <p>Dose 1: ____/____/____ Dose 2: ____/____/____</p> <p>OR Lab test proving immunity (attach lab reports)</p> <p>Measles: Immune - Titer value _____ Date: ____/____/____</p> <p>Mumps: Immune - Titer value _____ Date: ____/____/____</p> <p>Rubella: Immune - Titer value _____ Date: ____/____/____</p>
<p>★TETANUS/DIPHThERIA/PERTUSSIS</p> <p>A booster of Tetanus/Diphtheria within last ten years</p> <p>PLEASE NOTE: A one-time dose of Tdap is recommended, if at least 2-5 years since last Td</p> <p>Td Date ____/____/____ OR Tdap Date ____/____/____</p>	<p>★MENINGITIS</p> <p>Date vaccine administered: ____/____/____</p> <p>Menactra (MCV4) Menomune (MPSV4) Meningococcal (unspecified)</p> <p>OR WAIVER, if not immunized, must be signed and returned with this form. Waiver can be downloaded at:</p>

<p>★ TUBERCULOSIS RISK ASSESSMENT (RAQ)</p> <p>The enclosed RAQ Form must be completed and returned with this form. If your answer to any of the four questions on Page 1 is YES, your health care provider must complete Page 2 of the RAQ. The RAQ can be downloaded at: WPI.edu/admin/health</p>	<p>TO BE COMPLETED BY WPI HEALTH SERVICES</p> <table> <tr> <td>LOW RISK</td> <td>HIGH RISK</td> <td>Hx of positive PPD</td> </tr> <tr> <td>Date of PPD: ____/____/____</td> <td>Positive ____mm</td> <td>Negative</td> </tr> <tr> <td>Date of Chest X-ray: ____/____/____</td> <td>Normal</td> <td>Abnormal</td> </tr> <tr> <td>INH therapy</td> <td>No</td> <td>Yes Date started: _____ for # _____ months</td> </tr> </table>	LOW RISK	HIGH RISK	Hx of positive PPD	Date of PPD: ____/____/____	Positive ____mm	Negative	Date of Chest X-ray: ____/____/____	Normal	Abnormal	INH therapy	No	Yes Date started: _____ for # _____ months
LOW RISK	HIGH RISK	Hx of positive PPD											
Date of PPD: ____/____/____	Positive ____mm	Negative											
Date of Chest X-ray: ____/____/____	Normal	Abnormal											
INH therapy	No	Yes Date started: _____ for # _____ months											

PART III: STRONGLY RECOMMENDED IMMUNIZATIONS (to be completed by a medical provider)

<p>VARICELLA (Chicken Pox)</p> <p>History of Disease: No Yes at age: _____</p> <p>OR</p> <p>Lab test proving immunity (attach lab report) Immune Titer value _____ Date: ____/____/____</p> <p>OR</p> <p>Vaccine Dose 1 ____/____/____</p> <p>Vaccine Dose 2 ____/____/____</p>	<p>HEPATITIS A</p> <p>Hepatitis A Vaccine (at least 6 months apart)</p> <p>Dose 1 ____/____/____ Dose 2 ____/____/____</p> <p>Combined Hepatitis A and B Vaccine</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>	<p>HUMAN PAPILLOMAVIRUS (HPV)</p> <p>Vaccine (at 0, 2 and 6 month intervals)</p> <p>Gardasil Other</p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>
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❖ IMPORTANT NOTICE ❖

Failure to comply with the Massachusetts Immunization Law will result in a hold being placed on your registration.

PHYSICAL EXAMINATION

Physical Exam required within the past year for all students.

Freshmen and transfer student athletes must have a physical exam within 6 months of sport participation.

STUDENT'S NAME: _____ DATE OF EXAM: _____

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Height _____ ft. _____ in. Weight _____ lbs. BMI _____ BP _____ / _____ Pulse _____

Athletes Cardiovascular Exam required for clearance Precordial Auscultation (supine and standing) to murmurs specifically related to verticular out flow obstruction: Supine:

Assess femoral artery pulses to rule out coarctation.

Assess for physical stigmata of Marfan's Syndrome

Assess brachial artery BP while sitting

Standing:

IF THE STUDENT IS UNDER YOUR CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE US WITH ADDITIONAL INFORMATION TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

ALLERGIES: (medications, insect venom, foods, etc.) _____

Type of Reaction _____ Does the student have an Epi-pen? Yes No

CURRENT MEDICATIONS: _____

Do you have any **dietary recommendations**? No Yes (Please specify): _____

Please note any **additional recommendations** regarding this student: _____

RECOMMENDATIONS for PHYSICAL ACTIVITY

Unlimited Limited (specify):

Please check the appropriate box above.

Students are NOT eligible to practice or participate in intercollegiate sports until this form has been completed and submitted to the Health Center.

The athletic trainer and/or coach may have access to the physical examination report of students who elect to participate in athletics. _____

Student Signature

HEALTH CARE PROVIDER (please print) _____

Address: _____

Phone (____) _____ **FAX** (____) _____

PROVIDER'S SIGNATURE (**required**) _____