



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 <b>or</b> Age at Death	State of Health <b>or</b> 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<br>problem       | 16. High blood pressure      | 25. Mononucleosis                      | 34. Ulcer/stomach        |
| 8. Chickenpox<br>(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)**

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

**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><b>★HEPATITIS B (Three doses required)</b></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><b>OR</b> Lab test proving immunity (attach lab report)</p> <p>Immune – Titer value _____ Date: ____/____/____</p>	<p><b>★MMR (Measles, Mumps, Rubella)</b></p> <p><b>Two</b> doses required, at least one month apart, after 12 months of age</p> <p>Dose 1: ____/____/____ Dose 2: ____/____/____</p> <p><b>OR</b> Lab test proving immunity (attach lab reports)</p> <p><b>Measles:</b> Immune - Titer value _____ Date: ____/____/____</p> <p><b>Mumps:</b> Immune - Titer value _____ Date: ____/____/____</p> <p><b>Rubella:</b> Immune - Titer value _____ Date: ____/____/____</p>
<p><b>★TETANUS/DIPHTHERIA/PERTUSSIS</b></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 ____/____/____ <b>OR</b> Tdap Date ____/____/____</p>	<p><b>★MENINGITIS</b></p> <p>Date vaccine administered: ____/____/____</p> <p>Menactra (MCV4) Menomune (MPSV4) Meningococcal (unspecified)</p> <p><b>OR WAIVER, if not immunized, must be signed and returned with this form.</b> Waiver can be downloaded at:</p>

<p><b>★ TUBERCULOSIS RISK ASSESSMENT (RAQ)</b></p> <p>The enclosed <b>RAQ Form</b> must be completed and returned with this form. If your answer to any of the four questions on Page 1 is <b>YES</b>, your health care provider must complete Page 2 of the RAQ. The RAQ can be downloaded at: WPI.edu/admin/health</p>	<p><b>TO BE COMPLETED BY WPI HEALTH SERVICES</b></p> <table border="0"> <tr> <td><b>LOW RISK</b></td> <td><b>HIGH RISK</b></td> <td><b>Hx of positive PPD</b></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>	<b>LOW RISK</b>	<b>HIGH RISK</b>	<b>Hx of positive PPD</b>	Date of PPD: ____/____/____	Positive ____mm	Negative	Date of Chest X-ray: ____/____/____	Normal	Abnormal	INH therapy	No	Yes Date started: _____ for # _____ months
<b>LOW RISK</b>	<b>HIGH RISK</b>	<b>Hx of positive PPD</b>											
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><b>VARICELLA (Chicken Pox)</b></p> <p>History of Disease: No Yes at age: _____</p> <p><b>OR</b></p> <p>Lab test proving immunity (attach lab report) Immune Titer value _____ Date: ____/____/____</p> <p><b>OR</b></p> <p>Vaccine Dose 1 ____/____/____</p> <p>Vaccine Dose 2 ____/____/____</p>	<p><b>HEPATITIS A</b></p> <p><b>Hepatitis A Vaccine</b> (at least 6 months apart)</p> <p>Dose 1 ____/____/____ Dose 2 ____/____/____</p> <p><b>Combined Hepatitis A and B Vaccine</b></p> <p>Dose 1 ____/____/____</p> <p>Dose 2 ____/____/____</p> <p>Dose 3 ____/____/____</p>	<p><b>HUMAN PAPILLOMAVIRUS (HPV)</b></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>
--	--	--

**❖ 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 ventricular 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) \_\_\_\_\_