

WASHINGTON COLLEGE
Student Health and Counseling – Health Form

Queen Anne Building
Chestertown, MD 21620
300 Washington Avenue

410-778-7261 Fax 410-810-7101

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 Mother/Guardian

Home Address Home Address

Country Country

Place of employment Place of employment

Work # Work #

Home # Cell # 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 (If yes please list type)

Pulse Respirations BP Height Weight

PHYSICAL REVIEW: Please describe fully any abnormalities.

Head and scalp Genitals
Eyes: Visual Acuity R L Hernia
Corrective Lenses Musculo-skeletal:
Ears Injuries or defects
Nose, Sinuses Spine, posture
Throat: Tonsils & Adenoids Condition of feet and arches
Thyroid Other
Teeth & Gums Central Nervous System
Dental Caries Knee Jerk Biceps
Lungs/Breath Sounds Gait Station
Breast & Nodes Motor Sensory
Cardiovascular Other
Murmurs Skin
Other Abdomen (Liver, Spleen, Masses, Tenderness)

Note: Any positive cardiac findings will require a release from a cardiologist before student can participate in athletics.

Genitourinary

Females: Irregular Period Severe Cramps Excessive Flow

Date and Results of last Pap Smear (Recommended)

Please list any prior surgeries, include dates:

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

Limitations or Special Conditions:

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

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

Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_ ( )-\_\_\_\_\_  
Address \_\_\_\_\_  
Country \_\_\_\_\_ Date of Enrollment \_\_\_\_\_

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)

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

1. Mantoux test with PPD within the last six months. If you have traveled out of the country since the date of your test, you should have it repeated.  
Date given: \_\_\_\_\_ Date read: \_\_\_\_\_ Results: Induration \_\_\_\_\_ mm

Please note the following guidelines:

- If the area of induration is greater than 5mm and you are in any way immunocompromised, a chest x-ray is required.
  - If the area of induration is greater than 10mm and you are a foreign-born student or have had BCG vaccine, a chest x-ray is required.
  - If the area of induration is greater than 15mm, a chest x-ray is required.
  - If you have had a positive Mantoux test in the past, you will need to submit a copy of a written chest x-ray report which has been done within the past year.
  - If your Mantoux test is positive and your x-ray is negative, you must have counseling regarding INH therapy. Please include date of counseling, signature of provider who did the counseling and the treatment decision/plan. (attach a separate sheet.)
- If you required a chest x-ray, a copy of the written chest x-ray report must be included with this health form. Please do not send the x-ray.

**B. TETANUS-DIPHTHERIA**

1. Completed primary series of tetanus-diphtheria immunizations \_\_\_\_\_  
Month Day Year
2. Received tetanus-diphtheria booster within the last 10 years  
or Tdap booster (preferred) \_\_\_\_\_  
Month Day Year

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

1. Dose 1 - Immunized at 12 months or after and before 5 years \_\_\_\_\_  
Month Day Year
2. Dose 2 - Immunized at 5 years or later \_\_\_\_\_  
Month Day Year

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

1. Completed primary series of polio immunization \_\_\_\_\_  
Month Day Year
- Last booster \_\_\_\_\_  
Month Day Year

**E. HEPATITIS A** Dose #1 \_\_\_\_\_ Date \_\_\_\_\_ Dose #2 \_\_\_\_\_ Date \_\_\_\_\_

**F. HEPATITIS B** Dose #1 \_\_\_\_\_ Date \_\_\_\_\_ Dose #2 \_\_\_\_\_ Date \_\_\_\_\_ Dose #3 \_\_\_\_\_ Date \_\_\_\_\_

**G. MENINGITIS VACCINE** \_\_\_\_\_ type of vaccine \_\_\_\_\_  
(Required by Maryland law for college students) Month Day Year

**H. VARICELLA** (chicken pox) History of the disease? yes no Varicella antibody \_\_\_\_\_ R or NR

Date of vaccine: Dose #1 \_\_\_\_\_ Month Day Year Dose #2 \_\_\_\_\_ Month Day Year

**I. GARDASIL** Date of vaccine: Dose #1 \_\_\_\_\_ Month Day Year Dose #2 \_\_\_\_\_ Month Day Year Dose #3 \_\_\_\_\_ Month Day Year

Health Care Provider \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Phone \_\_\_\_\_

