Hood College Wellness Center  
(301) 696-3439  
The Wellness Center is open Aug. 1 - May 31 while classes are in session. If you have questions during the summer, you may call (301) 696-3575 to reach the Student Activities Office for assistance.

Important Information About Required Medical Forms and Immunizations

■ All attached forms must be completed and returned in the enclosed envelope by July 15 for fall enrollment or Jan. 15 for spring enrollment.

■ Registration for classes in subsequent semesters cannot be completed until your health forms are on file at the Wellness Center.

■ Please keep a copy of all completed forms for your records.

Forms to Complete

1. REPORT OF MEDICAL HISTORY: Fill out personal and family history yourself; the form must be signed by your healthcare provider.

2. REPORT OF MEDICAL EXAM: Have your physician fill out the Report of Medical Exam form. This form must be complete and on file at the Wellness Center before you can be eligible for Wellness Center services.

3. IMMUNIZATION RECORD: Required for all students and must be on file prior to arrival on campus. Your family physician should have these records.
   a) If you are a recent high school graduate, you may find your immunizations record at your high school.
   b) Your doctor may order a blood test for a Rubella and Rubeola titer to see if you are immune to these diseases.
   d) Maryland law requires all residential students have the meningococcal vaccine or sign a waiver declining the vaccination.

4. EMERGENCY CONTACT AND RELEASE FORM: Required for any emergency treatment to be initiated and allows us to contact the person you designate in an emergency. You may sign the form yourself if you are 18 or older. If you are under 18, your parent or guardian must sign.

Athletes:

Athletes will need to complete additional health related information and forms per NCAA requirements. This packet will be available at www.hoodathletics.com/athletics-about/sports-medicine/pre-participation-forms beginning June 1. For questions about the Pre-Participation Packet, contact Akira Kondo, head athletic trainer, at kondo@hood.edu or (301) 696-3836.
Meningococcal Disease And Vaccine Information

What You Need to Know

Maryland law requires that students enrolled in an institution of higher education in Maryland who reside in on-campus student housing must be vaccinated against meningococcal disease. An individual may be exempt from this requirement if:

1) the institution of higher education provides the student, or the student’s parent or guardian if the individual is a minor (under 18 years of age), detailed information on the risks associated with meningococcal disease and the availability and effectiveness of any vaccine, and

2) the individual or a minor student’s parent or guardian signs a waiver stating that the individual or the parent or guardian has received and reviewed the information provided and has chosen that the student will not be vaccinated against meningococcal disease.

What is Meningococcal Disease?

Meningococcal disease is a rare but life-threatening illness, caused by the bacterium Neisseria meningitidis. It is a leading cause of bacterial meningitis (an infection of the brain and spinal cord coverings) in the United States. The most severe form of the disease is meningococcemia, an infection of the bloodstream by this bacterium.

Deaths from meningococcal disease have occurred among Maryland college students in recent years. Students living in dormitories or residence halls are at increased risk. The Maryland Department of Health and Mental Hygiene encourages meningococcal vaccination of higher education students.

About 2,600 people get meningococcal disease each year in the United States. Ten to 15 percent of these people die in spite of treatment with antibiotics. Of those who live, 10 percent lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded or suffer seizures or strokes.

About the Vaccine

Meningococcal vaccine can be effective in preventing four types of meningococcal disease. The vaccine is not effective in preventing all types of the disease, but it does help to protect many people who might become sick if they don’t get the vaccine. Drugs such as penicillin can be used to treat meningococcal infection. Still, about one out of every 10 people who get the disease dies from it, and many others are affected for life.

A vaccine, like any medicine, is capable of causing serious problems, such as a severe allergic reaction. People should not get meningococcal vaccine if they have ever had a serious allergic reaction to a previous dose of meningococcal vaccine. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given (which is usually under the skin of the upper arm). A small percentage of people who receive the vaccine develop a fever.
REPORT OF MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Last, First and Middle Names</th>
<th>Social Security Number</th>
<th>Gender</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Address (number and street)</td>
<td>City</td>
<td>State</td>
<td>ZIP</td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Gender</td>
<td>Date of Birth</td>
<td></td>
</tr>
<tr>
<td>Class You Are Entering:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**This Form is to be Completed and Signed by the Student, and signed by the healthcare provider**

The information reported on this form is strictly for the use of the Health Center and the Athletic Department and will not be released to anyone without your knowledge and consent. This information will be used, if necessary, solely as an aid to provide necessary health care while you are a student at Hood.

### Family History

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Any health problems</th>
<th>If deceased, cause of death</th>
<th>Age at death</th>
<th>Have any of your blood relatives ever had any of the following?</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Personal History

— Please answer all questions. Comment on all positive answers in space below or on additional sheet.

1. Have you ever had any surgeries?  
   - Yes
   - No
   If yes, please list: ____________________________________________________

2. Have you ever stayed overnight in the hospital for any reason?  
   - Yes
   - No
   If yes, reason: ______________________________________________________

3. Has your physical activity been restricted during the past five years?  
   (Give reasons and duration) ___________________________________________

4. Are you taking medication(s) on a regular basis?  
   - Yes
   - No
   If Yes, please note medication(s) and dosage(s): ________________________

5. Have you ever been concerned with or received treatment for depression, anxiety, eating disorder or other emotional problems?  
   - Yes
   - No
   If Yes, give details: __________________________________________________

6. Are you allergic to any drugs, serums, foods or other substances?  
   - Yes
   - No
   If yes, please list: __________________________________________________

7. Are there any other reasons for which you have seen your doctor repeatedly?  
   - Yes
   - No
   Please list: __________________________________________________________

8. Have you ever passed out during exercise or become dizzy during exercise?  
   - Yes
   - No

9. Have you ever experienced chest pain during exercise?  
   - Yes
   - No

10. Have you ever had a concussion or neck injury?  
    - Yes
    - No

11. Have you ever broken a bone or had to wear a cast and/or had any injury to any joint?  
    - Yes
    - No

12. Have you ever suffered a heat related illness?  
    - Yes
    - No

13. Have you ever had convulsions (seizures) or epilepsy?  
    - Yes
    - No

14. Have you ever been unconscious?  
    - Yes
    - No

15. Do you have asthma or wheeze or cough after exercise?  
    - Yes
    - No

16. Do you wear contacts or eye glasses?  
    - Yes
    - No

17. Do you wear dental bridges, plates or braces?  
    - Yes
    - No

18. Do you have only one of any paired organ?  
    - Yes
    - No

19. Have you ever used any substances to enhance your performance?  
    - Yes
    - No

20. Have you been tested for sickle cell trait?  
    - Yes
    - No

21. (Women Only) Have you ever experienced amenorrhea (absence of regular periods) while engaged in strenuous exercise?  
    - Yes
    - No

Please check the sport(s) you intend to play:

- Collision Sports:  
  - Men’s Lacrosse
  - Basketball
  - Softball
  - Soccer
  - Field Hockey
  - Volleyball
  - Women’s Lacrosse

- Non Contact Sports:  
  - Tennis
  - Cross-Country
  - Golf
  - Swimming
  - Track and Field

**Remarks or Additional Information (Please use additional sheet)**

Student’s Signature __________ Date __________

Reviewed by Healthcare Provider (MD, CRNP, PA) __________ Date __________
This Form is to be Completed and Signed by a Health Care Provider

To the Examining Physician: Please review the student’s history and complete the section below. Please comment on all positive answers. This student has been accepted at Hood College. The information supplied will not affect her or his status; it will be used only as a background for providing health care, if necessary. This information is strictly for the use of the Health Center and the Athletic Department, and will not be released without student consent.

BP / Height (inches) Weight (lbs) BMI
Corrected Vision Right 20/ Left 20/
Urinalysis: Sugar Albumin Micro Protein
HEMOGLOBIN OR HEMATOCRIT grms/%
Sickle Cell Solubility Test (Required for Student Athletes): Yes No Decline - Fill out the waiver included in Student Athlete Packet

Are there any abnormalities of the following systems: (Describe fully. Use additional sheet if needed.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Additional Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>Head, Ears, Nose, Throat</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>Eyes</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>Respiratory</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>Cardiovascular</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>Hernia</td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td>Genitourinary</td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td>Neuropsychiatric</td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td>Metabolic/Endocrine</td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td>11.</td>
<td></td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>12.</td>
<td></td>
<td>Neck</td>
</tr>
<tr>
<td>13.</td>
<td></td>
<td>Shoulder</td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td>Elbow</td>
</tr>
<tr>
<td>15.</td>
<td></td>
<td>Wrist/Hand</td>
</tr>
<tr>
<td>16.</td>
<td></td>
<td>Spine (scoliosis)</td>
</tr>
<tr>
<td>17.</td>
<td></td>
<td>Hip</td>
</tr>
<tr>
<td>18.</td>
<td></td>
<td>Knee</td>
</tr>
<tr>
<td>19.</td>
<td></td>
<td>Ankle</td>
</tr>
<tr>
<td>20.</td>
<td></td>
<td>Feet</td>
</tr>
<tr>
<td>21.</td>
<td></td>
<td>Other</td>
</tr>
</tbody>
</table>

Is there loss or seriously impaired function of any paired organ? Yes No Explain:
Do you have any recommendations regarding the care of this student? Yes No (If yes, please explain on a separate sheet.)
Is the patient now under treatment for any medical or emotional condition? Yes No
Recommendation for physical activity (Physical Education, Intercollegiate and Intramural): Unlimited Limited, Explain:

Cleared after completing evaluation/rehabilitation for:

Not Cleared for: Collision Sports: Yes men’s lacrosse
Contact Sports: Yes basketball softball soccer field hockey volleyball women’s lacrosse
Noncontact Sports: Yes tennis cross-country golf swimming track and field
If a student is participating in a sport, please send a release form if the student has had orthopedic surgery within one year.

Remarks or Additional Information (Please use additional sheet)

Physician’s signature: Print physician’s last name:
Address:
Phone: Date:
This Form is to be Completed and Signed by a Health Care Provider

Proof of immunity is required prior to registration. Any contraindications to immunizations must be documented.

Status:  ☐ Undergraduate  ☐ Graduate  ☐ Full-time  ☐ Part-time

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required)
   1. Dose No. 1 given at age 12-15 months or later
      No. 1 __________/__________
           Month       Year
   2. Dose No. 2 given at age 4-6 years or later, and at least one month after first dose
      No. 2 __________/__________
           Month       Year

B. TETANUS-DIPHTHERIA
   Tetanus-Diphtheria (Td) booster within the last 10 years
       __________/__________
           Month       Year

C. POLIO: Check One
   Primary series of immunization completed with:
   __________ oral vaccine  __________ inactivated  __________E-IPV
   Last booster date __________/__________/__________
           Month     Day     Year

D. MENINGOCOCCAL TETRAVALENT (A, C, Y, W-135) (Maryland requires all residential students receive the meningococcal vaccine or sign a waiver below to the vaccination.)
   Tetravalent conjugate (preferred; data for revaccination pending):  Date __________/__________
                                                                    Month       Year
   Tetravalent polysaccharide (acceptable alternative if conjugate is not available;
   revaccinate every 3-5 years if increased risk continues):  Date __________/__________
                                                                    Month       Year
                __________/__________
           Month       Year
WAIVER:
I decline the meningococcal vaccine at this time. ___________________________  Date __________/__________
                                           Month       Year

E. TUBERCULOSIS SCREENING
1. Does the student have signs or symptoms of active tuberculosis disease?  ☐ Yes  ☐ No
   (If No, proceed to No. 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including
tuberculin skintesting, chest x-ray and sputum evaluation as indicated.)
2. Is the student a member of a high-risk* group or is the student entering the health professions?  ☐ Yes  ☐ No
3. Tuberculin Skin Test:
   Date Given: __________/__________/__________  Date Read: __________/__________/__________
          Month   Day   Year        Month   Day   Year
   Result: _______ (Record actual mm of induration, transverse diameter; if no duration, write “0”)
   Interpretation (based on mm of induration as well as risk factors): Positive _______ Negative _______
4. Chest X-ray (required if tuberculin skin test is positive) Result: Normal _______ Abnormal _______
   Date of Chest X-ray __________/__________/__________
          Month   Day   Year

*Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, U.S.A., U.S. Virgin Islands, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Austria or New Zealand.
RECOMMENDED BUT NOT REQUIRED IMMUNIZATIONS

A. VARICELLA

1. History of Disease  ☐ Yes  ☐ No

2. Immunization:
   a. Dose No. 1
      No. 1 __________/__________  
         Month Year
   b. Dose No. 2, given at least one month
      after first dose, if age 13 years or older
      No. 2 __________/__________  
         Month Year

B. HEPATITIS B

1. Immunization
   a. Dose No. 1 __________/__________  
      b. Dose No. 2 __________/__________  
      c. Dose No. 3 __________/__________  
      Month Year Month Year Month Year

HEALTH CARE PROVIDER INFORMATION

Name __________________________________________________________

Address _______________________________________________________

Signature ______________________________ Phone ___________________