



**Hood College Health Services
at Frederick Health Toll House
501 West 7th Street Frederick, MD 21701
Phone: 301-698-8374, option 1, then hold
Fax: 301-698-0182**



Hood College Health Services staff is committed to maintaining confidentiality of student medical information. Information will not be released without written consent of the student. If younger than 18, parent/guardian/spouse/partner must provide consent on the Emergency Contact & Release Form (pg 7).

**ALL STUDENTS
must return completed medical forms by:
June 30 for fall enrollment.
November 30 for spring enrollment.**

Forms may be returned to Health Services by:

1. **Fax:** 301-698-0182 with a confidential cover page.
2. **In person** to Lori Cavanaugh, Health Services Nurse at Frederick Health Urgent Care at 501 W 7th St Frederick, MD 21701.
3. Hood College has partnered with Med+Proctor to provide secure medical form verification. For a one-time fee of \$10, students can register, upload required forms for expedited review, and enjoy lifetime access to their medical records through the platform. Register [here](#).

Forms ALL STUDENTS must complete:

- **REPORT OF MEDICAL HISTORY (pg. 2):** Student fills out personal and family history. Must be reviewed and signed by your healthcare provider.
- **REPORT OF MEDICAL EXAM (pg. 3):** Health care provider to complete and sign medical exam. Exam may be completed in 12 months of arriving to campus. Student athletes may different requirements.
- **IMMUNIZATION RECORD (pg. 4-5):** If you are a recent high school graduate, you may find your immunizations record at your high school.
 - Maryland law requires **all residential students** have the meningococcal vaccine or sign a waiver declining the vaccination. See page 6 for more information.
- **EMERGENCY CONTACT AND RELEASE FORM (pg. 7):** Required for emergency treatment to be initiated and allows us to contact the person you designate in an emergency. If you are younger than 18, your parent/guardian/spouse/partner must sign.
- **PROOF OF HEALTH INSURANCE (pg. 7):** Proof of health insurance is required to attend Hood College. If coming from out of state, confirm that your insurance can be accepted in Maryland.

Course registration cannot be completed until health forms are on file at Health Services.
Residential students will not receive a housing assignment or be permitted to move in unless these forms have been received.

Keep a copy of all forms for your records.

REPORT OF MEDICAL HISTORY - This form must be completed and signed by the student, and signed by the health care provider. The information reported on this form is strictly for the use of Health Services. Documents may be shared with athletic training staff and/or the department of nursing if relevant. It 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.

PLEASE PRINT ABOVE Last Name First and middle names Date of birth Email address

Permanent address (number & street) City State Zip Code Cell Phone

Marital status: ☐ Single ☐ Married ☐ Other

Class you are entering: ☐ First year ☐ Soph. ☐ Jr. ☐ Sr. ☐ Grad.

Gender Identity: _____

Preferred Name: _____

	Age	Any health problems	If deceased, cause of death	Age at death	Have any of your blood relatives had any of the following?	Yes	No	Relationship
Father					Tuberculosis			
Mother					Diabetes			
Siblings					Kidney Disease			
					Heart Disease			
					Arthritis			
					Stomach Disease			
					Asthma, Hay Fever			
					Epilepsy, Seizures			
					High Blood Pressure			

Personal History: Please answer all questions. Comment on all positive answers in space below or on additional sheet.

- Have you ever had any surgeries? ☐ Yes ☐ No If yes, please list: _____
- Have you ever stayed overnight in the hospital? ☐ Yes ☐ No If yes, reason: _____
- Has your physical activity been restricted during the past five years? (Give reasons and duration) _____
- Are you taking medication(s) regularly? ☐ Yes ☐ No If yes, please note medication(s) and Dosage(s): _____
- Have you ever been concerned with or received treatment for depression, anxiety, eating disorder or other emotional problems? ☐ Yes ☐ No
If yes, give details: _____
- Are you allergic to any drugs, serums, foods or other substances? ☐ Yes ☐ No If yes, please list: _____
- Are there any other reasons for which you have seen your doctor repeatedly? ☐ Yes ☐ No
If yes, please list: _____
- Have you ever passed out during exercise or become dizzy during exercise? ☐ Yes ☐ No
- Have you ever experienced chest pain during exercise? ☐ Yes ☐ No
- Have you ever had a concussion or neck injury? ☐ Yes ☐ No
- Have you ever broken a bone or had to wear a cast and/or had any injury to any joint? ☐ Yes ☐ No
- Have you ever suffered a heat related illnesses? ☐ Yes ☐ No
- Have you ever had convulsions (seizures) or epilepsy? ☐ Yes ☐ No
- Have you ever been unconscious? ☐ Yes ☐ No
- Do you have asthma or wheeze or cough after exercise? ☐ Yes ☐ No
- Do you wear contacts or eyeglasses? ☐ Yes ☐ No
- Do you wear dental bridges, plates, or braces? Do you wear orthotics, protective braces or supports while playing sports? ☐ Yes ☐ No
- Do you have only one of any paired organ? (Eye, ear, kidney, lungs, etc.) ☐ Yes ☐ No If yes, please list _____
- Have you ever used any substances to enhance your performance? ☐ Yes ☐ No If yes, please list _____
- Have you been tested for sickle cell trait? ☐ Yes ☐ No If yes: ☐ Positive ☐ Negative
- 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 at Hood College:

☐ basketball ☐ soccer ☐ field hockey ☐ volleyball ☐ women's lacrosse ☐ men's lacrosse ☐ baseball
☐ softball ☐ tennis ☐ cross-country ☐ golf ☐ swimming ☐ track and field ☐ women's ice hockey

Do you intend to enter Hood's Nursing Program? ☐ Yes ☐ No

Student signature: _____

Date: _____

Reviewed by health care provider: (MD, CRNP, PA): _____

Date: _____

Report of Medical Exam - ALL STUDENTS

To the examining provider: This student has been accepted at Hood College. The information supplied will not affect his or her status; it will be used only as a background for providing necessary health care. This information is strictly for the use of Health Services, athletic training staff and/or the department of nursing if relevant. It will not be released without student consent. **Physical must be completed in the 12 months before entering College.**

PLEASE PRINT Last Name	First and middle names	Date of birth	Cell Phone
BP _____ / _____ Height (inches) _____			
Weight (lbs) _____ BMI _____			
Sickle Cell solubility Test (REQUIRED for student athletes): ☐ Positive ☐ Negative			
Must attach copy of sickle cell solubility test results with submission of records in order to participate in Athletics.			

Are there any abnormal findings for the systems listed below? If yes, please explain. (Use additional sheets as needed.)

	Yes	No	Additional Comments
1. Head, ears, nose, throat			
2. Eyes			
3. Respiratory			
4. Cardiovascular			
5. Gastrointestinal			
6. Hernia			
7. Genitourinary			
8. Neuropsychiatric			
9. Metabolic/endocrine			
10. Skin			
11. Musculoskeletal			
12. Neck			
13. Shoulder			
14. Elbow			
15. Wrist/hand			
16. Spine (scoliosis)			
17. Hip			
18. Knee			
19. Ankle			
20. Feet			
21. Other			

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: ☐ Unlimited ☐ Limited

Documentation/Explanation: _____

Not cleared for sports. Please explain why. _____

Cleared for sports after completing evaluation/rehabilitation for: _____

Please use additional sheet for any remarks or information

Provider's signature: _____ Print provider's last name: _____

Practice Address: _____

Practice Phone: _____ Exam Date: _____

IMMUNIZATION RECORD - ALL STUDENTS

PLEASE PRINT Last Name

First and middle names

Date of birth

Cell Phone

This form must be completed and signed by a health care provider. Proof of immunization, or titer with appropriate results, is required prior to registration. Any contraindications to immunizations must be documented. If a student needs an exemption/accommodation for a required vaccine, they must reach out to wellness@hood.edu immediately.

Immunizations	
A. MMR (Measles, Mumps, Rubella) REQUIRED .	
1. Dose No. 1 given at age 12-15 months or later	No. 1 _____(mo.)/_____(yr.)
2. Dose No. 2 given at age 4-6 years or later, at least one month after first dose	No. 2 _____(mo.)/_____(yr.)
OR	
TITER: _____(mo.)/_____(yr.)	Results: _____
If titer is negative for immunity, or student has not received childhood doses, 2 doses of the vaccine are required at least 28 days apart.	
1. Dose No. 1	No. 1 _____(mo.)/_____(yr.)
2. Dose No. 2 given at least 28 days after first dose	No. 2 _____(mo.)/_____(yr.)
B. Tdap or Td booster REQUIRED (Tdap _____(mo.)/_____(yr.) AND Td booster 10 years after Tdap _____(mo.)/_____(yr.)	
C. COVID -19- HIGHLY RECOMMENDED	
Manufacturer (circle ☐ Pfizer ☐ Moderna ☐ Novavax ☐ Johnson & Johnson ☐ Other WHO Approved Vaccine	
Dose No. 1 _____	
Dose No. 2 _____	
Dose No. 3 _____	
Please attach a copy of your vaccination card.	
D. MENINGOCOCCAL TETRAVALENT (A, C, Y, W-135) Maryland REQUIRES all residential students receive the meningococcal vaccine or sign a waiver to the vaccination (page 6).	
Meningococcal conjugate vaccination: Dose No. 1: _____(mo.)/_____(yr.) Dose No. 2: _____(mo.)/_____(yr.) REQUIRED	
Serogroup B Meningococcal vaccination: Dose No. 1: _____(mo.)/_____(yr.) Dose No. 2: _____(mo.)/_____(yr.) RECOMMENDED	
E. VARICELLA - HIGHLY RECOMMENDED	
Dose No. 1 given at age 12-15 months	_____ (mo.)/_____ (yr.)
Dose No. 2 given at age 4-6 years	_____ (mo.)/_____ (yr.)
If student had chicken pox in childhood, a titer is required	
TITER: _____(mo.)/_____(yr.)	Results: _____
If no primary series received during childhood, or titer is negative for immunity, student must receive 2 doses of vaccine at least 28 days apart.	
Dose No. 1	_____ (mo.)/_____ (yr.)
Dose No. 2 (at least 28 days after first dose)	_____ (mo.)/_____ (yr.)
HEPATITIS B IS REQUIRED FOR ALL NURSING STUDENTS AND HIGHLY RECOMMENDED FOR ALL STUDENTS	
F. HEPATITIS B	
Dose No. 1	_____ (mo.)/_____ (yr.)
Dose No. 2	_____ (mo.)/_____ (yr.)
Dose No. 3	_____ (mo.)/_____ (yr.)
OR	
TITER: _____(mo.)/_____(yr.)	Results: _____

Provider's signature: _____ Print provider's last name: _____

Address: _____

Phone: _____ Date: _____

IMMUNIZATION RECORD (cont'd)

PLEASE PRINT Last Name

First and middle names

Date of birth

Cell Phone

G. POLIO - HIGHLY RECOMMENDED

Primary series of immunization completed with: _____ oral vaccine _____ inactivated _____ E-IPV

Dose 1 given at 2months _____ (month/year)

Dose 2 given at 4 months _____ (month/year)

Dose 3 given at 6-18 months _____ (month/year)

Dose 4 give at 4-6 years _____ (month/year)

H. TUBERCULOSIS SCREENING

1. Does student have signs or symptoms of active tuberculosis disease: ☐ YES ☐ NO If NO, no action is needed. If YES, proceed with evaluation to exclude active tuberculosis disease including chest x-ray or sputum evaluation as indicated Type of test:

Date of test: _____ (mo.)/ _____ (yr.)

Test results: _____ No active TB present _____ Active TB present, treatment required

Provider's signature: _____ Print provider's last name: _____

Address: _____

Phone: _____ Date: _____

Meningococcal Disease And Vaccine Information - Residential Students ONLY

Name (PLEASE PRINT): _____ DOB: _____

Immunization records are required for ALL STUDENTS

What you need to know

Effective June 1, 2000, Maryland law requires that an individual enrolled in an institution of higher education in Maryland who resides in on-campus student housing **must** be vaccinated against meningococcal disease. To learn more about meningitis and the vaccine, you can visit the websites of the **Centers for Disease Control and Prevention (CDC)**.

What is meningococcal meningitis? Meningitis is rare. But when it strikes, this potentially fatal bacterial disease can lead to swelling of fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

How is it spread? Meningitis is spread through the air via respiratory secretions or close contact with an infected person. This can include coughing, sneezing, kissing or sharing items like utensils, cigarettes and drinking glasses.

What are the symptoms? Symptoms of meningococcal meningitis often resemble the flu and can include high fever, severe headache, stiff neck, rash, nausea, vomiting, lethargy and confusion.

Who is at risk? Certain college students, particularly students who live in residence halls, have been found to have an increased risk for meningococcal meningitis. All other students should consider the vaccine as well to reduce their risk for the disease.

Can meningitis be prevented? Yes. A safe and effective vaccine is available to protect against four of the five most common strains of the disease. The vaccine provides protection for approximately three to five years. Adverse reactions to the meningitis vaccine are mild and infrequent, consisting primarily of redness and pain at the injection site and rarely a fever. As with any vaccine, vaccination against meningitis may not protect 100 percent of all susceptible individuals. It does not protect against viral meningitis.

**IF YOU ARE NOT COMPLIANT WITH STATE OF MARYLAND REGULATIONS,
YOU WILL NOT RECEIVE YOUR HOUSING KEYS.**

PLEASE CHECK THE STATEMENT THAT APPLIES, SIGN AND RETURN TO HEALTH SERVICES:

☐ I have received the meningitis vaccine series (submit proof on IMMUNIZATION RECORD, page 4, Letter D).

☐ I have read and understand the information about meningitis, and I decline the meningitis vaccine at this time. I understand that I can decide to obtain the vaccine in the future.

Student's signature (if 18 or older)

Date

Parent/guardian/spouse/partner signature
(if student under 18)

PRINT NAME

RELATIONSHIP

Emergency Contact and Release Form- ALL STUDENTS

PLEASE PRINT Last Name

First and middle names

Date of birth

People to be notified in case of emergency

In case of emergency, especially in the event that the student is unable to give permission for medical or psychological treatment, it may be necessary to have a release from parents, a spouse, or another person who can legally authorize treatment. The College reserves the right to utilize emergency contact information without restriction when deemed necessary. Students are strongly encouraged to list a parent/guardian or spouse as their primary emergency contact.

Name	Relationship	Cell Phone	Home Phone	Work Phone
Name	Relationship	Cell Phone	Home Phone	Work Phone

Release for emergency treatment

In the event that I am unable to give permission for myself, and a parent, guardian, spouse or partner cannot be reached, I give Hood College permission to seek and obtain emergency medical or psychological care for me.

Signature of Student

Date

NOTE: Parent/guardian/spouse/partner signature is required for students younger than 18 years of age.

Signature of Parent/Guardian/Spouse/Partner

Relationship

Date

Release of information

I authorize release of my medical/medical billing information to the following individuals (**PLEASE PRINT**):

Name	Relationship	Phone

Signature of Student

Date

Medical Insurance Information - REQUIRED FOR ALL STUDENTS

Primary

Name of Policy Holder: _____

Signature of Policy Holder: _____

Date of birth: _____ SSN: _____

Insurance Company: _____

Policy #: _____

Group #: _____

Type of Coverage: HMO PPO/PPN POS HSA

Name of Health Care Provider: _____

Phone: _____

Is a referral needed from your health care provider for you to be seen by a specialist? ☐ Yes ☐ No

Does your insurance company provide out-of-network and/or out-of-state benefit? ☐ Yes ☐ No

Check with your insurance company prior to arriving to campus to determine coverage in Frederick, MD.

Attach a photo copy of the front and back of insurance card.