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

Hood College Health and Counseling Services provides care Aug.1 – May 31.
If you have questions during the summer, please call Health Services.

Hood Health and Counseling 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. (See Emergency Contact & Release Form)

Information about required medical forms and immunizations

ALL STUDENTS (RESIDENTIAL AND COMMUTER)
must return completed medical forms by:
July 31 for fall enrollment
December 1 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 a Health Services nurse during Hood College Advising Days on campus or at Health Services from 8 a.m.–8 p.m. Mon-Fri, 8 a.m.–6 p.m. Sat-Sun
3. U.S. Mail to: Hood College Health and Counseling Services, FMH Toll House, 501 W. 7th Street, Frederick, MD 21701. Please mark it "confidential."

- Course registration cannot be completed until health forms are on file at Health Services. Residential students will not be permitted to move in unless these forms have been received.
- **Keep a copy of all completed forms for your records.**

Forms ALL STUDENTS must complete:

- **REPORT OF MEDICAL HISTORY**: Fill out personal and family history yourself; the form must be signed by your healthcare provider.
- **REPORT OF MEDICAL EXAM**: Have your health care provider complete this form. This form must be complete and on file at Health Services.
- **IMMUNIZATION RECORD:** Required and must be on file prior to arrival on campus. Your health care provider should have these records.
- 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 2 for more information.**
- **EMERGENCY CONTACT AND RELEASE FORM:** Required for 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 younger than 18, your parent/guardian/spouse/partner must sign.

Meningococcal Disease And Vaccine Information

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), https://www.cdc.gov/meningococcal/index.html, and https://www.cdc.gov/vaccines/vpd/mening/public/index.html.

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

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.

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

( ) I have received the meningitis vaccine series (submit proof on IMMUNIZATION RECORD)

( ) 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

FAX TO: 301-698-0182 ***OR*** **DELIVER TO**: HOOD COLLEGE HEALTH SERVICES, 501 W. 7TH ST., FREDERICK, MD 21701

Any questions or concerns, please contact Dee Engel Oliva, RN, at 301-698-8374, Option 1 (HOOD)

Report of Medical History

PLEASE PRINT Last, first and middle names | Date of birth | Email address

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

Marital status: ___ Single ___Married ___Other
Gender Identity: _____

Class you are entering: ___ First year ___Soph. ___ Jr.___Sr.____Grad.
Preferred Name: _____

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, Athletics, and the Dept. of Nursing. 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.

Family History:

	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.

1. Have you ever had any surgeries? ___Yes ___No If yes, please list: _____
2. Have you ever stayed overnight in the hospital? ___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) regularly? ___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
If yes, 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 illnesses? ___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 eyeglasses? ___Yes ___No
17. Do you wear dental bridges, plates, or braces? Do you wear orthotics, protective braces or supports while playing sports? ___Yes ___No
18. Do you have only one of any paired organ? (Eye, ear, kidney, lungs, etc.) ___Yes ___No If yes, please list_____
19. Have you ever used any substances to enhance your performance? ___Yes ___No If yes, please list_____
20. Have you been tested for sickle cell trait? ___Yes ___No If yes: ____Positive ____Negative
21. Have you ever experienced amenorrhea (absence of regular periods) while engaged in strenuous exercise? ___Yes ___No

Please use additional sheet for any remarks or information

Please check the sport(s) you intend to play:
Collision sports: ___men's lacrosse
Contact sports: ___basketball ___softball ___soccer ___field hockey ___volleyball ___women's lacrosse ___baseball
Non-Contact sports: ___tennis ___cross-country ___golf ___swimming ___track and field

Do you intend to enter the Nursing Program? ___Yes ___No

Student signature: _____ Date: _____

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

Report of Medical Exam

Athletes will need to complete additional health-related information and forms per NCAA requirements.

PLEASE PRINT Last, first and middle names Date of birth

To the examining provider: 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 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, the Athletic Dept. and the Dept. of Nursing and will not be released without student consent.

BP_____/_____ Height (inches) _____
Weight (lbs)_____ BMI_____
Corrected Vision _____ Right 20/_____ Left 20/_____ Both 20/_____
Urinalysis: Sugar_____ Albumin _____ Micro_____ Protein_____
HEMOGLOBIN/HEMATOCRIT _____ grms/%
Sickle Cell solubility Test (required for student athletes): ___ Positive ___Negative ___Decline (fill out waiver in Student Athlete Packet)

Are there any abnormalities of the following systems: (Describe fully. Use additional sheet if 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:
Collision sports: ___men's lacrosse
Contact sports: ___basketball ___softball ___soccer ___field hockey ___volleyball ___women's lacrosse ___baseball
Non-Contact sports: ___tennis ___cross-country ___golf ___swimming ___track and field

Cleared after completing evaluation/rehabilitation for: _____

Please use additional sheet for any remarks or information

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

Address:_____

Phone: _____ Date: _____

IMMUNIZATION RECORD (REQUIRED OF ALL STUDENTS)

_____ _____

PLEASE PRINT Last, first and middle names Date of birth

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.

Immunizations
A. MMR (Measles, Mumps, Rubella) Two doses 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 (Tdap _____(mo.)/_____(yr.) AND Td booster 10 years after Tdap _____(mo.)/_____(yr.)
C. POLIO: **Primary series of immunization completed with**: _____oral vaccine _____inactivated _____E-IPV 1. Dose No. 1 given at age 2 months No. 1 _____(mo.)/_____(yr.) 2. Dose No. 2 given at age 4 months No. 2 _____(mo.)/_____(yr.) 3. Dose No. 3 given at age 6-18 months No. 3 _____(mo.)/_____(yr.) 4. Dose No. 4 given at age 4-6 years No. 4 _____(mo.)/_____(yr.) **If primary series incomplete, or documentation not available, student must receive adult series of three doses of IPV. The first two should be administered 1 to 2 months apart; the third administered 6 months after the second.** 1. Dose No. 1 No. 1 _____(mo.)/_____(yr.) 2. Dose No. 2 given 1 to 2 months after first dose No. 2 _____(mo.)/_____(yr.) 3. Dose No. 3 given 6-12 months after second dose No. 3 _____(mo.)/_____(yr.)
D. MENINGOCOCCAL TETRAVALENT (A, C, Y, W-135) Maryland requires all residential students receive the meningococcal vaccine or sign a waiver to the vaccination. 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 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, first and middle names Date of birth

E. TUBERCULOSIS SCREENING REQUIRED FOR ALL STUDENTS

1. Does student have signs or symptoms of active tuberculosis disease: ____YES ____NO

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

FOR STUDENTS ENTERING LEVEL 2 NURSING FALL SEMESTER ONLY

1. Does student have signs or symptoms of active tuberculosis disease: ____YES ____NO
If **NO,** proceed to #2
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

2. Did student receive BCG? ____YES ____NO
If **NO**, proceed to #3.
If **YES**, chest x-ray required.
Date of x-ray: _____(mo.)/_____(yr.) _____ No active TB present _____ Active TB present, treatment required
If chest x-ray is clear, no further testing required.

3. Did student receive QuantiFERON Gold test? ____YES ____NO
If **NO**, proceed to #4.
If **YES**: Date given: _____ (mo.)/ _____ (yr.) Result: _____Positive _____Negative

If **QuantiFERON test is positive, chest x-ray required.**
Date of x-ray: _____(mo.)/_____(yr.) _____ No active TB present _____ Active TB present, treatment required
If **chest x-ray is clear, no further testing required.**

If student has no signs or symptoms of active TB, has not had BCG and has not had QuantiFERON Gold test, student must have 2 TB skin tests administered 1-3 weeks apart.

4. **Tuberculin skin test 1:**
Date given: _____ (mo.)/_____(day), _____ (yr.) Date read: _____ (mo.)/_____(day),_____(yr.)
Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0."
Interpretation (based on mm of induration as well as risk factors): _____Positive _____Negative
If **POSITIVE**, chest x-ray required. Date of x-ray: _____(mo.)/_____(yr.)
X-ray results: _____ No active TB present; SECOND SKIN TEST NOT REQUIRED _____ Active TB present, treatment required.

Tuberculin skin test 2:
Date given: _____(mo.)/_____(day),_____(yr.) Date read: _____ (mo.)/_____(day),_____(yr.)
Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0."
Interpretation (based on mm of induration as well as risk factors): _____Positive _____Negative

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

Address:_____

Phone: _____ Date: _____

Emergency Contact and Release Form

Student:

PLEASE PRINT Last, 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 of 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/billing information to the following individuals (**PLEASE PRINT**):

Name	**Relationship**	**Phone**
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____

Signature of Student Date

Medical Insurance Information

Primary

Name of Policy Holder: _____
Signature of Policy Holder: _____
Date of birth: _____ Social Security number: _____
Insurance Company: _____
Policy #: _____
Group #: _____
Type of Coverage: HMO PPO/PPN POS HSA
Name of Health Care Provider: _____
Phone: _____

Secondary

Name of Policy Holder: _____
Signature of Policy Holder: _____
Date of birth: _____ Social Security number: _____
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

Please attach a copy of the front and back of insurance card.