HOOD COLLEGE

HEALTH OVERVIEW INFORMATION

Hood College Health Services at FMH Toll House

501 West 7th Street
Frederick, MD 21701
Phone: 301-698-8374
Fax: 301-698-0182

Important Information About Required Medical Forms and Immunizations

- **The Report of Medical History, Report of Medical Exam, Immunization Record and Emergency Contact forms must be completed and returned to the Health Center. The four required forms should be returned to the Health Center by July 31 for fall enrollment or January 1 for spring enrollment.**
- **Forms may be returned in the following ways:**
  1) **Fax directly to the Health Center at 301-698-0182 with a confidential cover page.**
  2) **Hand them to a nurse during Hood College Advising Days on campus or drop them off at the Health Center during office hours (Mon-Fri, 8 a.m.-8 p.m., and Sat-Sun, 8 a.m.-6 p.m.)**
  3) **U.S. Mail: Hood College Health Center, FMH Toll House, 501 West 7th Street, Frederick, MD 21701 (marked confidential).**
- **Registration for classes in subsequent semesters cannot be completed until your health forms are on file at the Health Center. Resident students will not be permitted to move in unless these forms have been received.**
- **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 Health Center before you can be eligible for Health 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.
   c) **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 Jennie Bowker, head athletic trainer, at bowker@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.

Confidentiality

The Hood Health Center staff is committed to maintaining the confidentiality of student medical information. Such information will not be released without written consent of the student (refer to Request for Medical Records form) or unless required by law or other special circumstances outlined by the FERPA regulations. If a student has not reached 18 years of age, the parent or guardian may be asked to give permission for certain procedures.

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REPORT OF MEDICAL HISTORY

Last, First and Middle Names _____ Date of Birth _____

Permanent Address (number and street) _____ City _____ State _____ ZIP _____ Cell Phone _____ Email Address _____

Marital Status: ❑ Single ❑ Married ❑ Other **Class You Are Entering:** ❑ First-Year ❑ Sophomore ❑ Junior ❑ Senior

Gender Identity:_____ **Preferred Name**_____

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

	Age	Any health problems	If deceased, cause of death	Age at death	Have any of your blood relatives ever had any of the following?			
Father						Yes	No	Relationship
Mother					Tuberculosis			
Brothers					Diabetes			
					Kidney Disease			
					Heart Disease			
					Arthritis			
Sisters					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 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? 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. (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

Contact Sports: ❑ 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

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REPORT OF MEDICAL EXAM

Last, First and Middle Names _____ Date of Birth _____

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): ❑ Positive ❑ Negative ❑ 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.)**

	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 (Physical Education, Intercollegiate and Intramural) ❑ Unlimited ❑ Limited, Explain:

_____

Cleared after completing evaluation/rehabilitation for: _____

Not Cleared for: Collision Sports: ❑ men's lacrosse

Contact Sports: ❑ basketball ❑ softball ❑ soccer ❑ field hockey ❑ volleyball ❑ women's lacrosse

Noncontact Sports: ❑ 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: _____

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IMMUNIZATION RECORD

Last, First and Middle Names _____ Date of Birth _____

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

REQUIRED INFORMATION

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: _____/_____/_____ (Month / Day / Year) Date Read: _____/_____/_____ (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)

continued

*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.

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IMMUNIZATION RECORD (cont.)

Last, First and Middle Names _____ Date of Birth _____

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 _____/_____ (Month / Year) b. Dose No. 2 _____/_____ (Month / Year) c. Dose No. 3 _____/_____ (Month / Year)

HEALTH CARE PROVIDER INFORMATION

Name _____

Address _____

Signature _____ Phone _____

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EMERGENCY CONTACT AND RELEASE FORM

Last, First and Middle Names _____ Date of Birth _____

Address _____ Email Address _____ Cell phone _____

■ 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.

1: _____

Name Relationship Cell Phone Home Phone Work Phone

Address _____

2: _____

Name Relationship Cell Phone Home Phone Work Phone

Address _____

■ 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: _____

Signature of Parent or Guardian _____ Date: _____

Note: For students age 18 years or under, a parent or guardian is required to sign this form.

■ Medical Insurance Information

Primary	Secondary
Name of Policy Holder _____	Name of Policy Holder _____
Signature of Policy Holder _____	Signature of Policy Holder _____
Date of Birth _____ Social Security Number _____	Date of Birth _____ Social Security Number _____
Insurance Company _____	Insurance Company _____
Policy # _____	Policy # _____
Group # _____	Group # _____
Phone _____	Phone _____
Type of Coverage: HMO PPO/PPN POS HSA	Type of Coverage: HMO PPO/PPN POS HSA
Name of Primary Physician (Family Doctor) _____	Name of Primary Physician (Family Doctor) _____
Phone _____	Phone _____

Is a referral needed from your primary care physician 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 sides of insurance card.

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