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 is open August 1 – May 31. If you have questions during the summer, please call Health Services, 301-698-8374, option 1.

Information about required medical forms and immunizations

- **ALL STUDENTS must complete the Report of Medical History, Report of Medical Exam, Immunization Record and Emergency Contact forms and return to Health Services July 31 for fall enrollment or January 1 for spring enrollment.**
- Forms may be returned in the following ways:
  1. Fax directly to Health Services at 301-698-0182 with a confidential cover page.
  2. Hand them to a Health Services nurse during Hood College Advising Days on campus or drop them off at Health Services during office hours (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."
- Registration for classes cannot be completed until your health forms are on file at Health Services. Residential 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. **Nursing students:** You will need copies of your forms prior to starting Nursing courses.

Forms to 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 before you can be eligible for care
- **IMMUNIZATION RECORD:** Required for all students and must be on file prior to arrival on campus. Your health care provider 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 provider 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.
- **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 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.hoodathletic.com/athletic-about/sports-medicine/pre-participation-forms beginning June 1. For questions about the Pre-Participation Packet, contact the Sports Medicine Center at 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 meningitis. 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.

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 and Counseling Services 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.

Report of Medical History

Last, first and middle names Date of birth

Permanent address (number & street) City State Cell Phone Email address

Marital status: ___ Single ___Married ___Other **Class you are entering:** ___ First year ___Soph. ___ Jr.___Sr.
Gender Identity: _____ **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. (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 ___baseball
Non-Contact sports: ___tennis ___cross-country ___golf ___swimming ___track and field

Do you intend to enter the Nursing Program? ___Yes ___No
Please use additional sheet for any remarks or information

Student Signature: Date:

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

Report of Medical Exam

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/_____
Urinalysis: Sugar_____ Albumin _____ Micro_____ Protein_____
HEMOGLOBIN OR 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: _____

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 ___baseball
Non-Contact sports: ___tennis ___cross-country ___golf ___swimming ___track and field
Please send release form if student has had orthopedic surgery within one year, and is participating in a sport.

Please use additional sheet for any remarks or information

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

Address:

Phone: Date:

IMMUNIZATION RECORD

_____ _____

Last name, Middle and First names Date of birth

This form is to 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.

Immunization	Documentation
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.)
TITER: _____(mo.)/_____(yr.) Results: _____	

B. Tdap or Td booster (Tdap or Tetanus booster within last 10 years) _____(mo.)/_____(yr.)

TITER: _____(mo.)/_____(yr.) Results: _____

C. POLIO: Check one

Primary series of immunization completed with:

_____oral vaccine _____inactivated_____E-IPV Last booster date: _____(mo.)/_____(yr.)

TITER: _____(mo.)/_____(yr.) Results: _____

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.

Meningococcal conjugate vaccination: Dose No. 1: _____(mo.)/_____(yr.) Dose No. 2: _____(mo.)/_____(yr.)

Serogroup B Meningococcal vaccination: Dose No. 1: _____(mo.)/_____(yr.) Dose No. 2: _____(mo.)/_____(yr.)

WAIVER: I have read and understand the enclosed Meningococcal Disease and Vaccine Information.
I decline the meningococcal vaccine at this time.

Student signature:_____Date: _____

E. TUBERCULOSIS SCREENING

1. Does student have signs or symptoms of active tuberculosis disease: ____YES ____NO
2. Did you receive BCG? ____YES ____NO
   If YES, chest x-ray required. X-ray results: ___No active TB present ___ Active TB present, treatment required.
3. If no to No. 1, proceed to No.4. If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated
4. Is student a member of a high-risk* group? _____YES _____NO
5. Is student entering the Nursing Program? ___YES ___NO If yes, student must have 2-step TB test, 1-3 weeks apart.

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

Tuberculin skin test 2 (for Nursing students only):

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

Chest x-ray (required if tuberculin skin test is positive) _____(mo.)/_____(yr.) Result :____Normal ____Abnormal

*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 countires 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.

IMMUNIZATION RECORD (cont'd)

_____ _____

Last name, Middle and First names Date of birth

THESE IMMUNIZATIONS ARE REQUIRED FOR NURSING STUDENTS AND HIGHLY RECOMMENDED FOR ALL STUDENTS.

F. VARICELLA (_____check here if you have had the disease)	
Dose No. 1	_____(mo.)/_____(yr.)
Dose No. 2, given at least one month after first dose, if age 13 years or older	_____(mo.)/_____(yr.)
TITER: _____(mo.)/_____(yr.) Results: _____	
G. HEPATITIS B	
Dose No. 1	_____(mo.)/_____(yr.)
Dose No. 2	_____(mo.)/_____(yr.)
Dose No. 3	_____(mo.)/_____(yr.)
TITER: _____(mo.)/_____(yr.) Results: _____	

HEALTH CARE PROVIDER INFORMATION

Name _____ Date: _____

Address _____

Signature _____ Phone: _____

Emergency Contact and Release Form

Last, first and middle names | Date of birth

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

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.

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

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

Signature of Parent/Guardian/Spouse/Partner | 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 sides of insurance card.