Tufts University
Health Service
124 Professors Row
Medford, MA 02155

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Tufts
UNIVERSITY

Directions for Completing this Form

Complete pages 1 through 3 before meeting with your Primary Medical Care Provider. Take all six pages with you to your doctor's appointment. Mail the completed forms to the Health Service at the address shown to the left. **Be certain to sign the Consent for Treatment.**

HEALTH EXAMINATION REPORT FOR UNDERGRADUATE STUDENTS

The information requested on this form is for the use of the Tufts University Health Services and will not be released to anyone without your knowledge and consent except as permitted by the Family Educational Rights and Privacy Act of 1974 or as required by law.

Student Data

Class of ______ Expected Year of Graduation from Tufts

Date ______ (MM/DD/YY)

Student Name ______ Last ______ First ______ MI

School Entering ______________________ **Gender** ______________________

☐ **Undergraduate**

Social Security # ______

Marital Status ______
S - Single
M - Married
D - Divorced
P - Partnered

Birth date ______ (MM/DD/YY)

Mailing Address

______ Number and Street

______ City ______ State ______ Zip Code

______ Country

Cell Phone # ______ - ______ - ______

Email Address ______

Birthplace ____

Emergency Contact

Primary Contact ______ Relationship

______ Last Name ______ First ______ MI

______ Number and Street ______ - ______ - ______ Phone

______ City ______ State ______ Zip Code ______ Country

Parents/Guardian

______ Last Name ______ First ______ MI ______ - ______ - ______ Work Phone ______ Occupation

______ Address if different from student ______ - ______ - ______ Home Phone ______ Email Address

______ City ______ State ______ Zip Code ______ Country

______ Last Name ______ First ______ MI ______ - ______ - ______ Work Phone ______ Occupation

______ Address if different from student ______ - ______ - ______ Home Phone ______ Email Address

______ City ______ State ______ Zip Code ______ Country

Student's Spouse/Partner

______ Last Name ______ First ______ MI ______ - ______ - ______ Work Phone ______ Occupation

______ If different from student ______ - ______ - ______ Home Phone ______ Email Address

______ City ______ State ______ Zip Code ______ Country

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Student Name					
	Last Name		First		MI

Date of Birth		(mm/dd/yy)

Allergies: (food, medication, environment)

Significant Family History:

Personal History Check the box if you have had any of the following

☐	**Absence of Paired Organ** (eye, ear, kidney, testicle)	☐	**Eating Disorder**	☐	**Learning Disability**
☐	**Alcohol/Drug Problem**	☐	**Emotional Distress/Problems**	☐	**Long QT Syndrome**
☐	**Anemia**	☐	**Enlarged Spleen/Splenectomy**	☐	**Marfan Syndrome**
☐	**Anxiety**	☐	**Eye/Vision Problems**	☐	**Meningitis**
☐	**Asthma**	☐	**Fainting with Exercise**	☐	**Migraines/Headaches**
☐	**Back Problems**	☐	**Gynecological Problems**	☐	**Mononucleosis**
☐	**Bleeding Disorders**	☐	**Heart Murmur/Heart Problems**	☐	**Nose/Sinus Problems**
☐	**Cancer/Tumor/Cyst**	☐	**Hepatitis/Jaundice**	☐	**Palpitations or Arrhythmia**
☐	**Cardiomyopathy**	☐	**Hernia**	☐	**Seizures/Epilepsy**
☐	**Chicken Pox Illness or Vaccine**	☐	**High Blood Pressure**	☐	**Special Needs**
☐	**Chronic Cough w/Exercise**	☐	**High Cholesterol**	☐	**Thyroid Disease**
☐	**Concussion/Serious Head Injury**	☐	**Insomnia/Sleep Problems**	☐	**Throat/Tonsil Problems**
☐	**Depression**	☐	**Intestinal/Stomach Problems**	☐	**Tuberculosis**
☐	**Diabetes**	☐	**Joint Problems**	☐	
☐	**Ear Trouble/Hearing Loss**	☐	**Kidney Disease/Infections/Stones**	☐	

Explanation of any YES answers:

Hospitalizations, Major Injuries, Major Illness, Operation

Medications

Medications That You Take Regularly

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Student Name						Date of Birth		(mm/dd/yy)
	Last Name		First		MI			

Consent for College Students

Signatures are required for all students, irrespective of age and type of insurance.

Consent to Medical care and Counseling Services and to Release of Medical and Counseling Service Records.

STUDENT: I consent to medical care in the Tufts University Health Service and Tufts University Counseling Center.

I understand that the Tufts University Health Service (TUHS) and the Tufts University Counseling and Mental Health Service (CMHS) will, in general maintain and respect the confidentiality of any treatment and services provided to me. However, if I am hospitalized for a serious illness or if, in the professional judgment of the TUHS Medical Director or the Director of the CMHS, or their authorized representatives, it is reasonably necessary for my safety or the safety of others, I hereby consent to the release of information concerning any hospitalization of me and/or safety concerns relating to me to the Dean of Student Affairs and/ or their authorized representatives. The Dean of Student Affairs, the TUHS Medical Director, or the Director of CMHS (or their respective representatives) may, in their discretion, notify my parents, guardian, or immediate family. In addition, I understand that the medical staff and mental health staff are part of one organization and will communicate with one another when appropriate to ensure continuity and quality of care.

Student's Signature ____________ Print Name ____________ Date ______

Consent by Parent/Guardian: (If student is under 18 years of age)

I hereby grant permission to the TUHS Medical Director and the Director of the CMHS Director or their authorized representatives, to release information under the circumstances described above, and to furnish such medical care as my son/daughter/ward may require, including examinations, treatment, immunizations and so forth. The permission is conditioned on the understanding that in the event of serious illness or the need for hospitalization and/or major surgery, the TUHS Medical Director or the CMHS Director will use all reasonable efforts to contact me. Failure in such efforts, however, should not prevent them from providing such emergency treatment as may be necessary for the best interest of the life of my son/daughter/ward.

Signature of Parent/Guardian ____________ Print Name ____________ Date ______

Student will turn 18 on ____________
Month/Day/Year

ACKNOWLEDGEMENT of RECEIPT of NOTICE of PRIVACY PRACTICES

I have read the Tufts University Notice of Privacy Practices.

Name (Please Print) ____________ **I.D./S.S.#** ____________

Signature ____________ **Date** ____________

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Student Name					
	Last Name		First		MI

Date of Birth		(mm/dd/yy)

Physical Examination

Required for Undergraduates. Page to be completed by health care provider

To the examining clinician: Please review the student's history and complete the Physical Report below.

Physical examination must be performed within 12 months prior to registration

System	Normal	Abnormal
Skin	☐	☐
Eyes	☐	☐
Ears	☐	☐
Nose/Sinuses	☐	☐
Mouth/Throat/Dental	☐	☐
Neck/Thyroid	☐	☐
Heart	☐	☐
Lungs/Chest	☐	☐
Breasts	☐	☐
Abdomen	☐	☐
Neurologic	☐	☐
Extremities/Joints	☐	☐
Back	☐	☐
Genitourinary	☐	☐
Mental Status	☐	☐

Explanation of Abnormal Finding

Vital Signs

Male ☐ Female ☐

Height ____________

Weight ____________

Blood Pressure ____________

Pulse ____________

Respiration ____________

Clearance for participation in collegiate athletic program

Recommendations for participation in collegiate athletic program

☐ **Unlimited, cleared for full participation**	☐ **Not Cleared (Comments)**

☐ **Recommendations regarding ongoing medical or psychological/psychiatric care of this patient.** ☐ **None**

Clinician Signature

Date of Examination

Printed Name

Title

Phone Number ____ – ____ – ____

FAX Number ____ – ____ – ____

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Student Name			
	Last Name	First	MI

Date of Birth		(mm/dd/yy)

Immunization Record

Required for *ALL* College Students

Massachusetts state law requires the following immunizations of all students.

Immunizations

Measles, Mumps, and Rubella (MMR)

☐ **Combined MMR Vaccine 2 Doses Required**

	DATE GIVEN mm/dd/yy
Dose 1 Given on or after first birthday	
Dose 2 Given at least 1 month after Dose 1	

OR

☐ **Immunization or Proof of Immunity for each disease separately**

Measles

☐ **Measles 2 Doses Required**

Dose 1 Given on or after first birthday	
Dose 2 Given at least 1 month after Dose 1	

OR

☐ **If unable to document immunization dates you must provide Measles Serology Titer Results** ☐ **Immune** ☐ **Not Immune**

Mumps

☐ **Mumps 2 Doses Required**

Dose 1 Given on or after first birthday	
Dose 2 Given at least 1 month after Dose 1	

OR

☐ **If unable to document immunization dates you must provide Mumps Serology Titer Results** ☐ **Immune** ☐ **Not Immune**

Rubella

☐ **Rubella 1 Dose Required** — **Dose 1 Given on or after first birthday**

OR

☐ **If unable to document immunization dates you must provide Rubella Serology Titer Results** ☐ **Immune** ☐ **Not Immune**

Diphtheria-Tetanus

Dose 1 Completed Primary Series	
Dose 2 Td Booster within the last 10 years or	
Tdap within the last 10 years	

Hepatitis B

Required for all entering Students

Dose 1	
Dose 2 30 Days after 1st Dose	
Dose 3 4-6 Months after 1st Dose	
or supporting HbsAB Documentation — **Results:** ☐ **Immune** ☐ **Not Immune**	

Meningococcal Vaccine

Date Vaccine Given
or
Waiver Attached

Clinician Signature ____________________ **Date of Examination** ____________

Printed Name ____________________ Title __________

Phone Number ____ – ____ – ____

FAX Number ____ – ____ – ____

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Student Name						Date of Birth		(mm/dd/yy)
	Last Name		First		MI			

Tuberculosis Risk Assessment

Required for ALL Undergraduates and Graduate Students

To be completed by your health care provider or Tufts University Health Service

Preliminary Assessment

To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? ☐ **Yes** ☐ **No**

Were you born in a country with high rates of TB (see list below) ☐ **Yes** ☐ **No**

Have you traveled or lived for more than a month in one of the countries with a high rate of TB? ☐ **Yes** ☐ **No**

If you answered any of the above questions YES, a PPD test (also known as Mantoux) is required within 12 months of entering Tufts University

- **A history of Baccille Calmette-Guerin (BCG) vaccination does not remove the requirement**
- **If a student has had a positive PPD in the past, and has not been treated for latent TB, a chest X-ray is required within the last 12 months. (See Below)**
- **If a student has been treated for latent TB, no further testing is required but the treatment must be documented below.**

Treatment for positive PPD? ☐ **No** ☐ **Yes** **Date**

If YES, describe: **Medication** **Length of Treatment**

PPD (Mantoux) Test

If required by the TB risk assessment, the test must be completed within 12 months of entering Tufts University. **(Tine, Monovac, or Heaf tests are not an acceptable replacement for Mantoux)**

Date Read: ______ (dd/mm/yy) **Result:** ______ (actual mm of induration, transverse diameter)

Interpretation: ☐ **Positive (10 mm or more induration)** ☐ **Negative**

Chest X-ray (Required within 12 months of entering Tufts if PPD 10 mm or greater) **Date Performed** ______ (dd/mm/yy)

Result: ☐ **Normal** ☐ **Abnormal (describe):**

Countries with High Rates of TB

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Rep.
Chad
China
Colombia
Comoros
Congo
Congo DR
Cote d'Ivoire
Croatia
Djibouti
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iran
Iraq
Japan
Kazakhstan
Kenya
Kiribati
Korea-DPR
Korea-Republic
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Lithuania
Macedonia-TFYR
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova-Rep.
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Niue
N. Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russian Federation
Rwanda
St. Vincent &
The Grenadines
Sao Tome & Principe
Saudi Arabia
Senegal
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Spain
Sri Lanka
Sudan
Suriname
Syrian Arab Republic
Swaziland
Tajikistan
Tanzania-UR
Thailand
Timor-Leste
Togo
Tokelau
Tonga
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Wallis & Futuna Islands
W. Bank & Gaza Strip
Yemen
Zambia
Zimbabwe

Reviewing Clinician ____________________________

Date ____________________________