GORDON
COLLEGE

MEDICAL QUESTIONNAIRE

Your physical examination must be within one year of the date you enter Gordon College. **Completion of the medical questionnaire and immunization checklist is mandatory and must be sent to Admissions at least four weeks before the start of classes.** This information is confidential and will not be released without your consent.

Students: Please retain a copy of this completed record before submitting.

MEDICAL QUESTIONNAIRE CHECKLIST:

1. **STUDENT COMPLETES** student sections of the Medical Questionnaire.

2. **EXAMINING PHYSICIAN COMPLETES TB SCREENING AND IMMUNIZATION RECORDS.**
   Please ensure that student has received all vaccinations required by Massachusetts DPH.

3. **EXAMINING PHYSICIAN COMPLETES PHYSICAL EXAM FORM.**

4. **STUDENT MAILS COMPLETED MEDICAL QUESTIONNAIRE**
   to Admissions at least four weeks before the start of classes.

NOTE: Please compare your immunization record with the requirements of the Massachusetts Department of Health, listed in this medical questionnaire. Immunization requirements vary from state to state. While vaccines are available at Gordon's Health Center, they are not covered by insurance and can be costly. Please make every effort to complete these requirements before arriving to campus.

LAST NAME | FIRST | MIDDLE INITIAL | DATE OF BIRTH | GORDON I.D. NUMBER

I. TO BE COMPLETED BY STUDENT

Please note: The completed medical questionnaire is required of all Gordon College students. It should be mailed to Gordon College, to the attention of the Admissions Office, at least four weeks before the start of classes. **Registration for classes will not be permitted unless complete medical information is provided**.

This information is confidential and will not be released to anyone without your knowledge and consent. Please answer questions in Sections I and II **before** going to your physician for examination. Your physical examination must be **within one year** of the date that you enter Gordon College; except for competetive athletes which requires a physical within 6 months, per NCAA Division III regulations.

Full name _____ (Last / First / Middle initial) Preferred name _____

Gender: ☐ Female ☐ Male Birthdate (mo/day/yr) _____

Email _____ Cell phone _____

Home address _____ (Street / City / State/Country / Postal Code)

Father's name _____ Father's cell phone _____

Mother's name _____ Mother's cell phone _____

Emergency contact (other than parent) _____ Phone _____

HEALTH INSURANCE (Please attach a copy of insurance card, front and back)

Name and address of company** _____ Phone _____

Name of policy holder _____ Policy holder date of birth _____

Employer _____ Type of plan: ☐ HMO ☐ PPO ☐ Managed Care ☐ Other

Policy or certificate number _____ Group number _____

Does your insurance company require primary care physician authorization for referral to specialists? ☐ Yes ☐ No

Primary care physician _____

Phone _____ Fax _____

IMPORTANT INFORMATION | PLEASE READ AND COMPLETE

Statement by student (or parent / guardian, if student under 18)

(A) I have personally supplied the information in this Medical Questionnaire; it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent (below), unless otherwise permitted by law. I understand that my medical information may be shared with appropriate Gordon College departments that will assist in my academic success. (B) If I should be ill or injured and unable to sign the appropriate forms, I hereby give my permission for Student Health Services to release information from my (son/daughter's) medical record to a physician, hospital, or other medical personnel involved in providing (him/her) with emergency treatment and/or medical care. (C) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physician of the Student Health Center; this includes my child who is under the age of 18. I also grant permission for treatment and use of anesthesia in the event of emergency. (D) I am aware that the Health Center charges for some services and I will be billed through Student Financial Services. I accept personal responsibility for settling the account with the cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the college is unaffected by the existence of insurance coverage. (E) If I have elected coverage under the college health insurance policy, I hereby authorize the release of medical information necessary to process insurance claims.

I ☐ do ☐ do not authorize the Student Health Center staff to share medical information with parents/guardians/spouse during my enrollment at Gordon College.

Student signature (required) _____ Date _____

Parent/guardian signature _____ Date _____

NAME (PRINT) _____ DATE OF BIRTH _____

II. MEDICAL HISTORY: TO BE COMPLETED BY STUDENT

Allergies to _____ Do you carry an EpiPen? ☐ Yes ☐ No

	NO	YES	EXPLANATION
Do you have any condition or disability that limits your physical activities? (If yes, please describe.)			
Have you ever been a patient in any type of hospital? Surgeries? (When, where, and why.)			
Has your academic career been interrupted due to physical or emotional problems? (Please explain)			
Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details.)			

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require explanation.

FAMILY AND PERSONAL HEALTH HISTORY

Has any member of your immediate family (parents, siblings, grandparents) had any of the following?

	NO	YES	RELATIONSHIP
High blood pressure			
Stroke/Heart Disease			
Cancer			
Diabetes			
High cholesterol			
Thyroid disorder			

	NO	YES	RELATIONSHIP
Respiratory disease			
Blood or clotting disorder			
Alcohol/drug abuse			
Psychiatric illness/ Suicide			
Other			
Other			

Have you ever had or have you now? (Please check at right of item and if yes, indicate year of first occurrence.)

	NO	YES	YEAR
Cardiac abnormality			
High blood pressure			
Low blood pressure			
Rheumatic fever			
Anemia			
Hemophilia			
Sickle cell trait			
Asthma			
Tuberculosis			
Diabetes (type 1 or 2)			
Epilepsy/seizure disorder			
Headaches			
Head injury/concussion			
Hearing loss			
Impaired vision			
Skin Disease			
Measles, Mumps, Rubella			
Chicken Pox			

	NO	YES	YEAR
Arthritis			
Broken Bones			
Back or neck injury			
Paralysis			
Ehlers Danlos syndrome			
Menstrual disorder			
STD (specify)			
Hernia			
Pilonidal cyst			
Bladder infection			
Kidney infection			
Kidney stone			
Mononucleosis			
Gallbladder disease			
Hepatitis (specify)			
HIV/AIDS			
Thyroid disorder			
Auto Immune disorder (specify)			

	NO	YES	YEAR
Alcohol/drug use			
Eating disorder			
Depression			
Anxiety/panic			
Self harm (specify)			
OCD			
LD/ADD/ADHD			
Smoking/tobacco use			
IBS-C			
IBS-D			
Ulcerative colitis			
Crohn's disease			
Ulcer (gastrointestinal)			
Tumor/Cancer (specify)			
Chemo/radiation (specify)			
Other:			
Other:			
Other:			

NAME (PRINT) _____ DATE OF BIRTH _____

Please list any drugs, medicines, birth control pills, vitamins and minerals (prescription and nonprescription) you use and indicate how often you use them.

NAME	USE	DOSE

NAME	USE	DOSE

III. TUBERCULOSIS RISK SCREENING: TO BE COMPLETED BY HEALTH CARE PROVIDER

Tuberculosis screening should occur by conducting a risk assessment prior assessment prior to arrival on campus in conjunction with completion of the admission physical and immunization record. **If the student is at low risk, a PPD is not required for entrance into college**.

Persons with any of the following are considered at high risk for TB exposure and should have IGRA Blood test or skin testing unless a previous positive test has been documented.

RISK FACTORS

Recent close or prolonged contact with someone with active TB ☐ Yes ☐ No

Foreign born (or travel to/within) a high-prevalence area (e.g. Africa, Asia, Eastern Europe, or Central or South America) ☐ Yes ☐ No

Previous resident, employee, or volunteer in a high-risk congregate setting (such as, correctional facilities, nursing homes, hospitals, homeless shelters or residential facilities for patient with AIDS/HIV or drug treatment center ☐ Yes ☐ No

Medical condition associated with an increased risk of TB disease if infected (such as organ transplant recipient, diabetes, chronic renal disease, leukemias or lymphomas, Hodgkins's disease, low body weight, chronic malabsorption syndrome, prolonged corticosteroid therapy or immunosuppressive disorder) ☐ Yes ☐ No

Signs and symptoms of TB ☐ Yes ☐ No

POSITIVE SKIN TEST OR POSITIVE IGRA REQUIRES A CHEST X-RAY

Mantoux/Intermediate PPD or IGRA tests

1. **Date of POSITIVE test:** (mo/day/yr) _____ Testing Method: ☐ Skin Test IGRA Blood test: ☐ Quantiferon ☐ Tspot

2. **Chest X-Ray:** ☐ Normal ☐ Abnormal **Please attach a copy of the report (no discs or films)**
   Describe:

3. **Clinical Evaluation:** ☐ Normal ☐ Abnormal
   Describe:

4. **Treatment:** ☐ Yes ☐ No
   INH Treatment: Initiate Date _____ X _____ months Declined ( )
   Other _____

Healthcare provider signature _____ Date _____

Phone _____ Fax _____

NAME (PRINT) _____ DATE OF BIRTH _____

IV. IMMUNIZATION RECORDS: TO BE COMPLETED BY HEALTH CARE PROVIDER

Please note: All of the requirements below apply to ALL students: full- or part-time, resident or commuter and students visiting from another state or country.

MMR (Measles/Mumps/Rubella) Two doses with live vaccine required; first dose on or after 1st birthday or titers completed	Dose #1	Dose #2	
	Lab Immunity Date		
Tdap (within 10 years)	Date		
HEPATITIS B Series must be started prior to registration and completed within 6 months or titers completed	Dose #1	Dose #2	Dose #3
	Lab Immunity Date		
MENINGITIS One dose of MenACWY for students (less than age 22) received on of after the 16th birthday	Date #1	Date #2	☐ Menactra ☐ Menomune ☐ Menveo

NOTE: Please read meningitis information on the Health Service web site regarding Massachusetts law and the meningitis vaccination.

WAIVER: I have read and understand the information you provided about risks of meningococcal disease and the availability and effectiveness of the vaccine, but for religious or other reasons, I decline the meningococcal vaccine at this time.

Signature (student) _____ Date _____

Parent (if student under age 18) _____ Date _____

Polio:	**Yes**	**No**		
(TOPV) series completed	☐	☐	Date:	
(IPOL) series completed	☐	☐	Date:	
Adult Booster (age 16+)	☐	☐	Date:	
VARICELLA or history of disease			Dose #1	Dose #2 (or)
				Hx of Disease or Lab Immunity: ☐ Yes ☐ No Date:
HEPATITIS A (Recommended/not required)			Dose #1	Dose #2
HPV VACCINE (Recommended/not required)			Dose #1	Dose #2
				Dose #3
MENINGITIS B (Recommended/not required) Bexsero OR Trumenba			Dose #1	Dose #2
				Dose #3 (IF Trumenba)

Typhoid: ☐ Typhim or ☐ Vivotif

Dose #1 _____ (mo/day/yr)

Dose #2 _____ (mo/day/yr)

Yellow fever _____ (mo/day/yr)

Miscellaneous Vaccines (not listed above)

Vaccine name _____ Date given _____ (mo/day/yr)

Vaccine name _____ Date given _____ (mo/day/yr)

Vaccine name _____ Date given _____ (mo/day/yr)

PHYSICIAN INFORMATION

Health Care Provider's signature _____ Date _____

Print last name _____ Phone _____

Address _____ Fax _____

NAME (PRINT) _____ DATE OF BIRTH _____

V. TO BE COMPLETED BY EXAMINING HEALTH CARE PROVIDER

Please review the information in Section II and then complete the questions below. Your signature is required for this form to be valid. Incomplete questionnaires will be returned.

Date of Exam _____ Height _____ Weight _____ BMI _____

Temp _____ Pulse _____ Resp _____ BP _____

Will student be participating on a varsity (NCAA) sports team? ☐ Yes ☐ No Which sport? _____

ARE THERE ANY ABNORMALITIES? IF SO, DESCRIBE IN FULL	NO	YES	DESCRIPTION (ATTACH ADDITIONAL SHEETS IF NECESSARY)
Head, Ears Nose, Throat			
Eyes			
Respiratory			
Cardiovascular			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Neuropsychiatric			
Skin			
Mammary			

QUESTIONS BELOW ARE REQUIRED TO BE COMPLETED

	NO	YES
Has this student experienced significant weight change over the past year?		
If the BMI is less than 17 has the student been evaluated for disordered eating?		
Does the student have a diagnosed eating disorder? If YES, please specify.		
PLEASE NOTE* Students with a diagnosed eating disorder must be managed by the current PCP or arrange to establish a new PCP in the local area before the beginning of the academic year. The Health Center is willing to assist with monitoring, but cannot assume a primary care role. For further information, please call.		
Is the student under treatment for any medical or mental health condition? If YES, please explain. _____		
Is the student FIT TO PARTICIPATE in activities including, but not limited to, physical education classes, intramural events, athletic competitions and general exercise?		
Does the student require an Epi-pen?		
Diet Prescription (please check if applicable): This student requires the following diet prescription: ☐ Dairy-free ☐ Egg-free ☐ Gluten-free ☐ Nut-Free: all nuts/tree nuts/peanuts ☐ Soy-free ☐ Shellfish-free ☐ Other _____		

Healthcare provider signature _____ Date _____

Print name _____ Phone _____

Address _____ Fax _____