MITCHELL COLLEGE

STUDENT HEALTH FORM
PERSONAL & CONFIDENTIAL

Connecticut State Law and the policy of Mitchell College mandate that a completed health certificate be on file.

PLEASE PRINT or TYPE

Student Name: _____Sex: _____ Birth Date: _____

Address: _____

Telephone: _____Class: 20_____ Social Security # __ __ __ - __ __ - __ __ __ __

In Case of Emergency Notify:

1. _____
   Name Address Telephone Number

2. _____
   Name Address Telephone Number

STUDENT AUTHORIZATION FOR TREATMENT

I, hereby authorize Mitchell College Health and Wellness Services to provide medical treatment and services as they deem appropriate. This authorization will remain in effect as long as I am a student at Mitchell College. In the event of serious illness or injury, Parents or Guardian will be notified at the discretion of the professional staff.

_____ _____
Student Signature Date

_____ _____
Signature of Parent or Guardian (for students under 18 years of age) Date

LIST ALL HEALTH INSURANCE COVERAGE

Students are required to have medical coverage. Without identified insurance coverage you will be automatically enrolled and billed for the College Student Health Insurance Plan. For information on the college insurance plan, or to waive coverage, please visit: www.gallagherstudent.com.

Name of Insurance Company _____

Identification Numbers: _____

*Please provide student with any prescription card information.

_____ _____
Student Signature Date

Please Return Forms to Health Services:
437 Pequot Avenue New London, CT 06320
Phone: 860.701.5195 Fax: 860.701.5198 Email:Healthservices@mitchell.edu

MITCHELL COLLEGE

FAMILY HISTORY (To be completed by student)

Relative	Age	General Health	Past and/or Present Serious Illness	If deceased, cause of death	Age at death
Father					
Mother					
(Brother/Sister)					
(Brother/Sister)					
(Brother/Sister)					

MEDICAL HISTORY OF APPLICANT (To be completed by student)

Allergic to Medications? *If yes, please list:*
Severe Food Allergy? *If yes, please list:*
Insect Allergy? Y/N **Environmental Allergy? Y/N** **Is an Epipen prescribed? Y/N**
Prescription and Over The Counter Medications: *Please list and include reason and dosage:*
Current or Past Medical, Surgical, or Psychiatric Conditions: *Please list and include relevant medical information:*

Are you subject to headaches? *If yes, please describe:*

_____

Have you ever been unconscious? *If yes, please describe:*

_____

Has your weight fluctuated by more than 10 pounds during the past year? *If yes, please describe:*

_____

Have limits been placed on you as to amount and nature of physical exercise? *If yes, please describe:*

_____

Do you smoke? *If yes, how much per day?* _____

How much alcohol would you estimate you consume in one week? _____

Student Signature: _____ Date: _____

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Last Name	First Name	Date of Birth: ____/____/_____ Month Day Year

Height:	Weight:	Temperature:	Blood Pressure	Pulse	Vision R/L

Clinical Evaluation	Normal	Abnormal	Comments
Skin			
Head, ears, eyes, nose, throat, hearing, and visual acuity			
Mouth, teeth and gums			
Neck and thyroid			
Lungs/Chest			
Breasts			
Heart (supine and upright)			
Abdomen			
Genitalia			
Back/Spine			
Extremities/Musculoskeletal/Femoral Pulses			
Neurologic			
Emotional/Psychological			
Other findings			

Is this student cleared for full physical activity, including participation in intramural and club sports, and able to meet the physical and emotional demands of college life?

☐ Yes/Unlimited activity and fit for college ☐ No/Limited activity

Reason: _____

Recommendations: _____

I have reviewed the medical history and examined the student noted above; the information is accurate and complete to the best of my knowledge.

Signature of Healthcare Provider *(Parent or guardian cannot sign as the healthcare provider)*		Date	Phone
Print Name of Healthcare Provider	Address (include city and state)		Fax

MITCHELL COLLEGE

Incoming Undergraduate Vaccination Record

Last Name	**First Name**	**Date of Birth: ____/____/_____** Month Day Year

REQUIRED VACCINATIONS or PROOF OF IMMUNITY:

Measles-Mumps-Rubella Vaccine	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year	
OR Positive Titers for: Measles (Rubeola) Mumps Rubella	Titer Results: Measles: _____ Mumps: _____ Rubella: _____		PLEASE ATTACH ALL TITER RESULTS.
Varicella Vaccine	Date of Dose #1: ___/___/___ Month Day Year	Date of Dose #2: ___/___/___ Month Day Year	
OR Positive Titer for Varicella **OR** Physician Documented Disease (chicken pox).	Varicella Titer Results: _____	Date of Disease: ___/___/___ Month Day Year MD Signature: _____	PLEASE ATTACH ALL TITER RESULTS.
Meningococcal Vaccine - Quadrivalent Within the Past 5 Years. (ONLY IF LIVING ON CAMPUS*).	Date of Last Dose: ___/___/___ Month Day Year	*Select Type:* Menactra Nimenrix Menveo Mencevax ACWY Menomune	

RECCOMMENDED VACCINES:

Tetanus, Diptheria, Pertussis	1 dose within 10 years	____/___/__ Month Day Year		Select type: ☐Td ☐Tdap *(preferred)*
Polio Vaccine	Date series completed or 1 dose TPV	____/___/___ Month Day Year		
Hepatitis B Vaccine	Series of 3 doses	Date of Dose #1: ____/___/___ Month Day Year	Date of Dose #2: ____/___/___ Month Day Year	Date of Dose #3: ____/___/___ Month Day Year
Hepatitis A Vaccine	Series of 2 doses	Date of Dose #1: ____/___/___ Month Day Year	Date of Dose #2: ____/___/___ Month Day Year	
HPV Vaccine	Series of 3 doses	Date of Dose #1: ____/___/___ Month Day Year	Date of Dose #2: ____/___/___ Month Day Year	Date of Dose #3: ____/___/___ Month Day Year
Tuberculosis Skin Test (PPD) Within the Past 6 Months, **OR** Quantiferon Lab Test **OR** Chest Xray (if history of positive PPD)	Date of PPD Test: ____/___/___ Month Day Year Result: _____mm	Date of Quantiferon Test: ____/___/___ Month Day Year Date of Chest Xray: ____/___/___ Month Day Year Result:_____	PLEASE ATTACH QUANTIFERON LAB RESULT **OR** CHEST XRAY RESULT IF APPLICABLE	

Clinician Name	**Clinician Signature**		**Date**
Address (Include city and state)	**Email**	**Telephone**	**Fax**

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