Mitchell College Health Services Student Health Form

Student Information

Student Name: ______________________ **Birth Date:** ______________ **Sex:** ________

Address: ____

Cell Phone Number (in order to contact you ON campus)**:** ______________________________

Emergency Contacts

1. ____
Name Relationship Telephone Number

2. ____
Name Relationship Telephone Number

Health Insurance

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	Member ID Number	Group Number	Policy Holder Name and DOB

Student Authorization for Treatment

I, hereby authorize Mitchell College Health and Wellness Services to provide medical treatment and services as they deem appropriate. If I require services that incur a charge, I shall assume full financial responsibility. In the event of serious illness or injury, parents or guardians will be notified at the discretion of the professional staff. I understand that confidentiality may be broken if my life or that of another person is in danger. This authorization will remain in effect as long as I am a student at Mitchell College.

____
Student Signature Date

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

437 Pequot Avenue New London, CT 06320

Phone: 860.701.5195 Fax: 860.701.5198 Email: healthservices@mitchell.edu

MITCHELL COLLEGE

MEDICAL HISTORY Completed by STUDENT

Allergies: List and explain reaction

☐ No Known Allergies	Do you carry an EpiPen? ☐ YES ☐ NO
Food: ☐ Anaphylaxis	Medications: ☐ Anaphylaxis
Insect: ☐ Anaphylaxis	Seasonal/Environmental/Other: ☐ Anaphylaxis

Medications: List Prescription and OTC medications, DOSE, and reason.

Personal Medical History: Have you ever had or been diagnosed with the following conditions? Circle all that apply.

ADD/ADHD	Alcohol Abuse	Anemia	Anxiety	Asthma	Bipolar Disorder	Cancer
Cardiac Condition	Coagulation Disorder	Concussion	Diabetes	Depression	Eating Disorder	GI Conditions/IBS
GYN Conditions	Headache	Hepatitis B/C	Hypertension	HIV/AIDS	Mononucleosis	Mood Disorder
Seizures	Sickle Cell Disease	Thyroid Disorder	Tuberculosis	Unexpected Weight Changes		Urinary Tract Infections

Family Medical History: Have you ever had or been diagnosed with the following conditions? Circle all that apply.

Sudden death before age 50	Unexplained death	Heart Attack	Heart Disease	High Blood Pressure
Diabetes	Cancer	Asthma Lung Disease	Blood Clot	Stroke

Have you ever had a concussion? ☐ YES ☐ NO *If yes, how many?* ______________________

Have limits ever been placed on you as to the amount and nature of physical exercise? ☐ YES ☐ NO

Do you vape, smoke, or use tobacco? ☐ YES ☐ NO *If yes, how often?* _____________________

How much alcohol do you consume in one week? _________________________

Have you ever received treatment for any psychiatric, mental health, disordered eating or psychological concern? ☐ YES ☐ NO

If yes, please explain: ____

____

____

Do you need assistance finding a mental health provider close to campus? ☐ YES ☐ NO

List any additional information that Health Services should know about your physical and/or mental health, including surgical history.

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

I understand that failure to submit all required information will result in a hold on my student account. Clearance for registration, classes, and other activities is not granted until all required information is received.

____

Student Signature Date

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MITCHELL COLLEGE

Last Name	First Name	Date of Birth

Physical Examination Completed by HEALTHCARE PROVIDER

EXAM MUST BE COMPLETED WITHIN 1 YEAR PRIOR TO ENROLLMENT.

Date of Exam:

Height:	Weight:	BMI:	Blood Pressure	Pulse	Vision
					20/____ ☐Corrected

Clinical Evaluation	Normal	Abnormal	Comments
General			
Integumentary			
HEENT			
Respiratory *If student requires an inhaler for asthma symptoms, please provide asthma action plan if clinically indicated.			☐Asthma Action Plan
Cardiovascular			
Gastrointestinal			
Renal/ Urinary			
Gynecological (*Women Only)*			
Musculoskeletal			
Metabolic/ Endocrine			
Neurological			
Hematologic/Lymphatic			
Emotional/Psychological			
Other findings			

____
Provider Initials

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Last Name	First Name	Date of Birth

Part I: Tuberculosis (TB) Screening Questionnaire (to be completed by student or provider)

Please answer the following questions:

1) Have you ever had close contact with persons known or suspected to have TB disease? ☐ **YES** ☐ **NO**
2) Are you currently suffering from a condition or taking medication that causes you to be immunosuppressed? E.g. HIV infection, organ transplant recipient, or treated with immunosuppressive medication such as high dose steroids or TNF-alpha antagonists? ☐ **YES** ☐ **NO**
3) Were you born in one of the countries below? (If yes, CIRCLE the country/territories) ☐ **YES** ☐ **NO**
4) Have you traveled or lived for more than one month in one or more of the countries or territories listed below with a high prevalence of TB disease? (If yes, CIRCLE the countries/territories) ☐ **YES** ☐ **NO**

Afghanistan, Albania, Algeria, Angola, Anguilla, Argentina, Armenia, Azerbaijan, Bangladesh, Belarus, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cabo Verde, Cambodia, Cameroon, Central African Republic, Chad, China, China Hong Kong SAR, China Macao SAR, Colombia, Comoros Congo, Côte d'Ivoire, D.R. of Korea, D.R. of the Congo Djibouti Dominican Republic, Ecuador, El Salvador, Equatorial Guinea, Eritrea, Eswatini, Ethiopia Fiji, French-Polynesia, Gabon, Gambia, Georgia, Ghana, Greenland, Guam, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, India, Indonesia, Iraq, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao D.R., Latvia, Lesotho, Liberia, Libya, Lithuania, Madagascar, Malawi, Malaysia, Maldives, Mali, Marshall Islands, Mauritania, Mexico, Micronesia (Federated States of) Mongolia, Morocco, Mozambique, Myanmar, Namibia, Nauru, Nepal, Nicaragua, Niger, Nigeria, Niue, Northern Mariana Islands, Pakistan Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Sao Tome and Principe Senegal, Sierra Leone, Singapore, Solomon Islands, Somalia, South Africa, South Sudan, Sri Lanka, Sudan, Suriname, Swaziland, Tajikistan, Tanzania, Thailand, Timor-Leste, Togo, Tunisia, Turkmenistan, Tuvalu, Uganda, Ukraine, Uruguay, Uzbekistan, Vanuatu, Venezuela, Vietnam, Yemen, Zambia, Zimbabwe. *Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2017. Countries with incidence rates of ≥ 20 cases per 100,000 populations. For future updates, refer to http://www.who.int/tb/country/en/.*

If the answer to all of the above questions is NO, no further testing or further action is required.

If the answer is YES to any of the above questions, Mitchell College requires that Part 2 of this screening be completed by a health care provider prior to enrollment.

Part II. Clinical Assessment by Healthcare Provider

Clinicians should review and verify the information in Part 1. Students answering YES to any of the questions in Part I must follow up with appropriate testing. In most cases, a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) will be sufficient. An IGRA blood test is recommended if student previously received BCG immunizations.

Have you ever received the BCG Vaccine? ☐ YES ☐ NO ☐ UNKNOWN

TB SKIN TEST (Mantoux)	TB BLOOD TEST (IGRA)	CHEST X-RAY: (Required within 6 months for positive TB skin or blood test)	TREATMENT
Date Planted: ________ Date Read: __________ Induration: ___________	☐ Quantiferon ☐ T-Spot Date: _______________ Result: ☐ Positive ☐ Negative ☐ Indeterminate	Date: ______________ ☐ Normal ☐ Abnormal X-RAY report must be attached	☐ TB Infection ☐ Latent (inactive) ☐ Active TB Disease Treatment Completed Date: ____________

____
Provider Initials

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MITCHELL COLLEGE

Last Name	First Name	Date of Birth

Vaccination Record   Completed by HEALTHCARE PROVIDER

REQUIRED VACCINATIONS or PROOF OF IMMUNITY: **PLEASE ATTACH ALL TITER RESULTS**

Measles-Mumps-Rubella Vaccine 2 doses required or proof of positive titer	Date of Dose #1: ___________ Date of Dose #2: ___________	☐ Titers attached
Varicella Vaccine 2 doses required or proof of positive titer or history of disease confirmed by MD	Date of Dose #1: ___________ Date of Dose #2: ___________	Date of Disease: ___________ MD Signature: ___________ ☐ Titers attached
Meningitis Vaccine (Serogroup A,C,Y,W135) Must be administered **after age 16 and within the past 5 years prior to enrollment.** ***Only required if living on campus**	Date of Vaccine: ___________ Select Type: ☐ Menactra ☐ Menveo ☐ Other	☐ Commuter
Covid-19 Vaccine 2 doses required for Pfizer or Moderna 1 dose required for Johnson & Johnson *Please attach copy of Covid Vaccine Card	Select Manufacturer: ☐ Pfizer ☐ Moderna ☐ Johnson &Johnson ☐ Other ___________	Date of Dose #1: ___________ Date of Dose #2: ___________ Date of Dose #3: ___________ (Booster Dose **NOT** Required)

RECCOMMENDED VACCINES:

Meningitis B Vaccine ☐ Bexsero (2 dose series) ☐ Trumenba (2 or 3 dose series) *Highly recommended for all students living on campus	Date of Dose #1: ___________ Date of Dose #2: ___________ Date of Dose #3: ___________	**Adult Tetanus, Diphtheria, Pertussis** 1 dose every 10 years (sooner if injured) ☐ Td ☐Tdap	Date of Dose: __________
Hepatitis B Vaccine Series of 3 doses or titer	Date of Dose #1: ___________ Date of Dose #2: ___________ Date of Dose #3: ___________ ☐ Titers attached	**HPV Vaccine** Series of 3 doses	Date of Dose #1: _________ Date of Dose #2: _________ Date of Dose #3: _________
Hepatitis A Vaccine Series of 2 doses	Date of Dose #1: ___________ Date of Dose #2: ___________	**Tuberculosis Screening** SEE ATTACHED FORM	

MEDICAL EXEMPTION FORMS ARE AVAILABLE AT HEALTH SERVICES.

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Last Name	First Name	Date of Birth

Certification Completed by HEALTHCARE PROVIDER

Connecticut state law and the policy of Mitchell College mandate that a completed health certificate be on file. Failure to submit all required information will result in a hold on student accounts. All information will remain confidential in accordance with HIPAA laws.

Is this student cleared for full physical activity and able to meet the physical and emotional demands of college life? ***If NO, please attach letter explaining reason and recommendations.***

☐ YES ☐ NO/ Limited Activity

☐I have reviewed the student's tuberculosis risk assessment and performed the necessary screening as recommended by Connecticut Department of Public Health.

☐ I have reviewed the student's immunization records which are complete and up to date to the best of my knowledge. This includes the REQUIRED Meningococcal Serogroup A,C,Y,W135 vaccine. A medical exemption form has been completed if the required vaccinations are not clinically indicated.

☐ I have examined the above named student and reviewed the medical history. I confirm that the information above is accurate to the best of my knowledge.

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

Mandatory Student Health Checklist

☐ 2 Student Signatures -Authorization for treatment, Understanding of requirements
☐ Physical Exam within the past year- completed PE Form
☐ 2 Varicella Vaccines or Positive Titer
☐ 2 MMR Vaccines or Positive Titer
☐ Completed Covid Vaccine series (1 or 2 doses depending on manufacturer)
☐ Copy of Covid Vaccine card
☐ Meningitis Vaccine within 5 years if living on campus
☐ Submit all forms prior to enrollment via fax, email, or postal service

Forms may be submitted via fax, email, or postal service to Admissions.
Admissions@mitchell.edu Fax: 860-701-5090
Keep a copy of these forms until you are certain they have been received.
Failure to submit all required information will result in a hold on your student account.