SMITH COLLEGE

Schacht Center for Health and Wellness
and Pelham Medical Services

21 Belmont Avenue, Northampton, Massachusetts 01063
Phone 413-585-2800 Fax 413-585-4639 **smith.edu/health**

Deadlines:
June 15: Fall Admission, Undergraduate, Graduate, and Ada Comstock
January 19: Spring Admission

HEALTH FORM PACKET: REQUIRED OF ALL STUDENTS

- ► **All pages must be completed with name, date of birth, and Smith ID number, and signed as indicated.**
- ► **Failure to submit this information by the deadline will result in a hold on student accounts.**
- ► **Please complete this checklist and all required documentation.**

☐ **Page 1: Student information, medical insurance, consent, and financial responsibility.**
- Emergency contact must be a parent/guardian for students under age 18. One U.S. contact is preferred.
- Health insurance coverage is required for all students, as per Massachusetts law.
- Smith College offers a plan that is specifically designed to meet student needs. Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
- Students who waive the Student Health Insurance Plan must upload copies of both sides of their insurance cards.

☐ **Page 2: Immunizations: Proof of required immunizations or immunity by blood test.**
- Upload the enclosed form, completed and signed by your physician, OR a copy of your immunization record.
- Submit copies of blood test report(s) results if titers are being submitted.
- Questions about vaccine waivers should be directed to healthservices@smith.edu.

☐ **Page 3: Tuberculosis Risk Screening: Date of screening must be *no earlier than May 1, 2025*.**
- Tuberculosis screening questions must be completed and signed by the student or legally responsible parent/guardian.
- Testing is needed only if a student answers YES to any of the items on the screening questionnaire.

☐ **Page 4: Tuberculosis Medical Evaluation: Complete only if you answer YES to questions on page 3. Date of testing must be *no earlier than May 1, 2025*.**
- Medical provider (MD, DO, NP, PA) review and signature required if you answer YES to questions on page 3.
- Submit copies of written blood test report(s) and/or chest X-ray report(s), if applicable.

☐ **Page 5: Medical Examination Form.**
- Submit a copy of your recent physical exam: Date of exam must be *within 23 months prior to matriculation.*
- Your health care provider must review AND sign the medical examination form unless notes from a physical are submitted.

☐ **Page 6: NCAA Pre-Participation Exam: Complete only if you intend to play an NCAA sport.**
- Complete this form if you intend to play a team sport. *Not required for club/extracurricular sports.*
- Date of exam must be *within 6 months prior to matriculation and before arrival on campus.*
- EKG and referral to cardiology AND a copy of these records are required for any significant history and/or findings.
- Provide provider certification of negative sickle cell screening or a copy of a negative blood test result, as required by NCAA.

► **UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL.**
(https://smith.medicatconnect.com)
- Online instructions and additional forms are available at smith.edu/health.
- You may mail or fax records to 413-585-4639 if needed.
- *Do not email forms, health records, or test results. They will not be accepted.*

Failure to submit all required information by the deadline will result in a HOLD on student accounts.
Clearance for registration, classes, and other activities is not granted until all required information is received.

QUESTIONS? Please contact healthservices@smith.edu.
See website for information about health forms, insurance, services, and resources: smith.edu/health.

UPLOAD all information.
We do not accept emailed information due to confidentiality concerns.
Keep a copy of all information sent.

SMITH COLLEGE

This page must be completed by all students.
Student/parent/guardian signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

STUDENT INFORMATION

Chosen Name | Pronouns | Assigned Sex at Birth

Street Address

City/State/Region/Country/ZIP Code

Telephone | Email

Country of Birth | ☐ Undergraduate ☐ Ada ☐ Graduate ☐ Transfer Class of:

EMERGENCY CONTACT

Name of individual(s) over age 18 to be contacted in an emergency and who is able to make medical treatment decisions. *If the student is younger than age 18, the legally responsible parent(s) or guardian must be listed first. Please include a U.S. contact.*

Name | Relationship to Student

Telephone 1 | Telephone 2 | Email

Name | Relationship to Student

Telephone 1 | Telephone 2 | Email

MEDICAL INSURANCE – All students are automatically enrolled in the Student Health Insurance Plan.

- Health insurance coverage is required for all students per Massachusetts law. The Student Health Insurance Plan is available and is specifically designed to meet the needs of students. It is accepted by most off-campus providers in our local area without a referral, and covers vaccines and laboratory and radiology services. Deductibles and co-pays do apply.
- Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
- Students who waive the Student Health Insurance Plan should determine if LabCorp (on-site reference lab) is in-network and whether immunizations provided by the Schacht Center will be covered.

Students waiving the Student Health Insurance Plan MUST submit a copy of both sides of their insurance cards.

Students are responsible for any charges or services not covered by insurance.

FINANCIAL RESPONSIBILITY and CONSENT: Undergraduate, Graduate, and Ada Comstock Students only

I hereby give permission to the Schacht Center for Health and Wellness to provide me (or the aforementioned student under 18 years of age) with general, non-surgical medical treatment and diagnosis, including, but not limited to, immunizations or such other health care as the Schacht Center for Health and Wellness shall determine to be medically necessary or desirable. Further, in the event of a medical emergency when my emergency contact(s) identified above cannot be reached, I hereby give permission for the director of Smith College Health Services, or designee, to make treatment decisions for me (or the aforementioned student under 18 years of age), including, but not limited to, urgent or emergency care and hospitalization, if deemed necessary at the discretion of the Schacht Center for Health and Wellness in order to avoid delay which might jeopardize life and/or recovery. Finally, I understand that charges for any services at the Schacht Center for Health and Wellness that are not covered by medical insurance will be billed to my account, for that I accept full financial responsibility.

Signature of student **Date**

Required of all students

Signature of legally responsible parent or guardian **Date**

Required of all students under 18 years of age

This page is to be completed by the student/family. Upload this completed page to the patient portal at smith.edu/health.
Do not give this page to your doctor.

SMITH COLLEGE

This page must be completed by all students.
Physician signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

IMMUNIZATIONS

- **ALL students must comply with Massachusetts School Immunization Requirements.**

Failure to meet all requirements by the deadline will result in a hold on all student accounts.

Most U.S. retail pharmacies and walk-in or urgent care clinics can provide and administer vaccines.

REQUIRED IMMUNIZATIONS: Include dates of administration in MM/DD/YYYY format	Date Dose 1 MM/DD/YYYY	Date Dose 2 MM/DD/YYYY	Date Dose 3 MM/DD/YYYY	Date Dose 4 MM/DD/YYYY	TITER: Date and Result *Include copy of results if titers are performed*
Tetanus-Diphtheria-Pertussis Completed childhood primary series (date of **final dose** of DTP/DTaP)					N/A
Tdap (Adacel or Boostrix) 1 dose within 10 years					N/A
Hepatitis B 3 doses (0, 1 month, 4–6 months apart) **or** 2 doses f Heplisav after age 18 (Specify if Heplisav-B) **or** positive titer (lab report required)					
MMR: Measles, Mumps, Rubella **MMRV: Measles, Mumps, Rubella, Varicella** 2 doses of MMR or MMRV 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titers for each (lab report required) (*may waive for US birth before 1957*)					
Varicella (Chicken Pox) 2 doses 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titer (lab report required) or *provider-verified medical documentation of disease with date* (*may waive for US birth before 1980*)					
Quadrivalent Meningitis (Students age 21 or younger) (MenACWY/MCV4/Menactra/Menveo) 1 dose *on or after age 16*					N/A
HIGHLY RECOMMENDED IMMUNIZATIONS					
COVID-19 Please note the vaccine type in the corresponding date box.			(booster)	(booster)	N/A
Hepatitis A					N/A
Human Papillomavirus					N/A
Polio primary series completed before age 4					N/A
Meningitis B (Students under age 23) ☐ Bexsero ☐ Trumenba					N/A
Flu Vaccine					N/A
OTHER IMMUNIZATIONS					
Japanese Encephalitis (Ixiaro)					N/A
Rabies					N/A
Typhoid (injectable)					N/A
Typhoid (oral)					N/A
Yellow Fever					N/A

You must submit an official copy of your immunization records OR your physician must complete AND sign this form.

I HAVE REVIEWED THIS HISTORY WITH THE STUDENT AND ATTEST TO ITS ACCURACY.

Provider Name **M.D./ D.O. N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Upload this completed page to the patient portal at smith.edu/health.
Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

This page must be completed by all students.
Student/parent/guardian signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

TUBERCULOSIS (TB) RISK SCREENING (Required for ALL Students) **Complete within 3 months prior to matriculation.**

*If the answer to any question below is **YES**, the Tuberculosis (TB) Medical Evaluation Form on page 4 must be completed.*

		Date(s)
1. Have you ever had a positive tuberculosis (TB) skin test?	☐ Yes ☐ No	_____
2. Have you ever had close contact with anyone who was sick with TB?	☐ Yes ☐ No	_____
3. Have you ever been a resident, volunteer, and/or employee of a high-risk congretate setting (i.e., correctional facility, long-term care, or homeless shelter) or a health care worker who served clients who are at increased risk for active TB?	☐ Yes ☐ No	_____
4. Were you born in one of the countries listed below?	☐ Yes ☐ No	_____
5. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks?	☐ Yes ☐ No	_____

6. Please CIRCLE the country in which you were born AND any of the countries you lived in within the past five years, or traveled to for more than two weeks.

Afghanistan	Colombia	Indonesia	Mozambique	South Africa
Algeria	Comoros	Iraq	Myanmar	South Sudan
Angola	Congo	Kazakhstan	Namibia	Sri Lanka
Anguilla	Congo (Democratic Republic of)	Kenya	Nauru	Sudan
Argentina	Cote d'Ivoire	Kiribati	Nepal	Suriname
Armenia	Djibouti	Korea (Democratic People's Republic of)	Nicaragua	Tajikistan
Azerbaijan	Dominican Republic	Korea (Republic of)	Niger	Tanzania (United Republic of)
Bangladesh	Ecuador	Kyrgyzstan	Nigeria	Thailand
Belarus	El Salvador	Lao People's Democratic Republic	Niue	Timor-Leste
Belize	Equatorial Guinea	Lesotho	Northern Mariana Islands	Togo
Benin	Eritrea	Liberia	Pakistan	Tunisia
Bhutan	Eswatini	Libya	Palau	Turkmenistan
Bolivia (Plurinational State of)	Ethiopia	Lithuania	Panama	Tuvalu
Bosnia and Herzegovina	Fiji	Madagascar	Papua New Guinea	Uganda
Botswana	Gabon	Malawi	Paraguay	Ukraine
Brazil	Gambia	Malaysia	Peru	Uruguay
Brunei Darussalam	Georgia	Maldives	Philippines	Uzbekistan
Burkina Faso	Ghana	Mali	Qatar	Vanuatu
Burundi	Greenland	Marshall Islands	Romania	Venezuela (Bolivarian Republic of)
Cabo Verde	Guam	Mauritania	Russian Federation	Viet Nam
Cambodia	Guatemala	Mexico	Rwanda	Yemen
Cameroon	Guinea	Micronesia (Federated States of)	Sao Tome and Principe	Zambia
Central African Republic	Guinea-Bissau	Moldova (Republic of)	Senegal	Zimbabwe
Chad	Guyana	Mongolia	Sierra Leone	
China	Haiti	Morocco	Singapore	
China, Hong Kong SAR	Honduras	Somalia	Solomon Islands	
China, Macao SAR	India			

Source: https://www.acha.org/wp-content/uploads/2024/06/ACHA_Tuberculosis_Screening_May2024.pdf

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

If the answer to ANY of the questions above is YES:

☐ The Tuberculosis (TB) Medical Evaluation (page 4) must be completed and signed by a medical provider.

☐ You are required to have an Interferon Gamma Release Assay (IGRA blood test) or a Tuberculin Skin Test/PPD (TST) **if IGRA is not available**. This must be dated within 3 months of matriculation.

☐ If a Tuberculin Skin Test is completed, an IGRA blood test will be required upon arrival.

☐ A CHEST X-RAY is REQUIRED before arrival on campus for any positive IGRA blood test or skin tests.

Signature of student **Date**

Required of all students

Signature of legally responsible parent or guardian **Date**

Required of all students under 18 years of age

This page is to be completed by the student/family. Upload this completed page to the patient portal at smith.edu/health. Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

This page must be completed by all students who answered YES to any questions on the TB screening form (page 3). Provider signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

TUBERCULOSIS (TB) MEDICAL EVALUATION

Please Note: *Failure to provide complete documentation will result in the inability to travel to campus, register in classes, or participate in college-related events. Any person currently being treated for active TB will be required to provide documentation of treatment and meet with a medical provider upon arrival.* ***Any person being treated for active TB without documentation will not be allowed on campus.***

1. Does student have past or current diagnosis, signs, or symptoms of active tuberculosis disease? ☐ **NO** ☐ **YES**

Students with a history or current diagnosis of active tuberculosis must provide the following:

☐ Documentation from a tuberculosis specialist indicating that the student is **no longer infectious** and including treatment details:
  ☐ Name(s) of medication, dose, frequency taken
☐ Duration of treatment, start date(s) of treatment, date(s) treatment completed
☐ Copies of all sputum results and chest X-rays

2. Interferon Gamma Release Assay (IGRA): ***Required if any YES answers on page 3 or for any positive skin test.***

Type of Test: ☐ TSpot.TB test OR ☐ QFT-GIT ***Must be dated no earlier than May 1, 2025.***
(If Indeterminant, repeat IGRA testing will be required.)

☐ Please attach lab results.
- If IGRA is negative, no further action is required.
- If IGRA is not available, complete section 3 below.
- If IGRA is positive, a chest X-ray is required. Complete section 4 below.

3. Tuberculin Skin Test/PPD (TST): ***Only complete if IGRA testing is not available.*** *Must be dated no earlier than May 1, 2025.*
Please note: An IGRA blood test will be required upon arrival. Lab testing is billed to insurance.

Date given ___/___/_____ Date read ___/___/_____ **Result:**_____ mm of induration, transverse diameter
MM DD YYYY MM DD YYYY

Interpretation: ☐ **Negative** ☐ **Positive** (Chest X-ray required)

Interpretation of Tuberculin Skin Test guidelines: Interpretation is based on mm of induration and risk factors below.

Risk Factor	Result is considered **POSITIVE** if induration is equal or greater than:
Close contact with an individual with infectious tuberculosis	**5 mm or more**
Born in a country that has a high rate of tuberculosis	**10 mm or more**
Traveled or lived for two weeks or more in a country that has a high rate of tuberculosis	**10 mm or more**
No risk factor (Test not recommended)	**15 mm or more**

4. Chest X-ray: ***Required if IGRA is positive OR if skin test is positive. Must be dated no earlier than May 1, 2025.***

☐ Date of chest X-ray ___/___/_____ **Result:** Normal ____ Abnormal _____ *If ABNORMAL, consultation with a medical provider is needed for medical clearance prior to arriving on campus.*
MM DD YYYY
☐ Attach chest X-ray report
☐ Attach consultation note

I HAVE REVIEWED THIS FORM AND ATTEST THAT THE STUDENT IS AT LOW TO NO RISK FOR TUBERCULOSIS EXCEPT AS INDICATED ABOVE.

Provider Name **M.D./ D.O. N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Upload this completed page to the patient portal at smith.edu/health.
Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

This page must be completed by all students unless notes from a physical are submitted. Provider signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

MEDICAL EXAMINATION **Date of Exam**_____

Exam must be performed no earlier than August 1, 2023.

To be completed and signed by the health care provider. *No portion of this form may be completed by a student's family member.*

HEALTH HISTORY: ☐ No known significant medical history
Check and provide dates and details below if there is a significant medical history:

☐ Hospitalization	☐ Surgery	☐ Anaphylaxis	☐ Abnormal Pap Smear	☐ ADD or ADHD	☐ Anemia	☐ Anxiety
☐ Alcohol or Drug Abuse	☐ Asthma Bronchitis/ Pneumonia/Lungs	☐ Bipolar Disorder	☐ Blood Clot or Phlebitis	☐ Bowel Disease	☐ Cancer	☐ Depression
☐ Diabetes	☐ Ears or Hearing	☐ Eyes or Vision	☐ Eating Disorder	☐ Emotional or Mood Changes	☐ Heart Disease	☐ Heart Murmur
☐ Head Injury or Concussion	☐ High Blood Pressure	☐ Immune System	☐ Kidney Stones or Disease	☐ Learning Differences	☐ Liver or Hepatitis	☐ Tuberculosis
☐ Metabolic/ Endocrine	☐ Migraine or Other Headaches	☐ Mononucleosis	☐ Orthopedic or Bones	☐ Reproductive System/ Menstruation	☐ Sickle Cell	☐ Other:
☐ Weight Change	☐ Fainting or Loss of Consciousness	☐ Urinary Tract Infections	☐ Other:	☐ Other:	☐ Other:	☐ Other:

PHYSICAL EXAM: Height _____ **Weight** _____ **BMI** _____
BP_____ **HR** _____ **RR** _____

	Normal	Description	N/A
General constitutional			
Head Ears Eyes Neck Throat			
Heart / Cardiovascular			
Respiratory / Lungs			
Gastrointestinal			
Genitourinary			
Reproductive			
Neurological			
Immune / Lymphatic			
Hematologic / Blood			
Metabolic / Endocrine			
Psychiatric			

ALLERGIES: ☐ No Known Allergies ☐ Medications
☐ Food ☐ Insect Bites *If so, list below and describe reaction.*

MEDICATION: Does the student use any medications (Including inhalers, hormones, or contraception)
☐ Yes ☐ No

If yes: List names of medication, dose, and reason for use.

FAMILY HISTORY: Has anyone in immediate family had:
☐ Sudden death before age 50 ☐ Heart Attack
☐ Blood Clot ☐ Heart Disease ☐ High Blood Pressure
☐ Diabetes ☐ Cancer ☐ Asthma ☐ Lung Disease
☐ Kidney Stone

ATHLETICS EXAMINATION:
Is student participating in an intercollegiate sport?
☐ Yes ☐ No

If yes: Complete the NCAA Athletic Pre-Participation Physical Exam (page 6)

DESCRIBE ABOVE: _____

_____

_____

_____

Provider Name **M.D./ D.O. N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Upload this completed page to the patient portal at smith.edu/health.
Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

This page is required only for NCAA athletes.
Physician signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
Exam must be performed within 6 months of matriculation. MM DD YYYY

Date of Exam_____

NCAA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM THIS FORM IS REQUIRED FOR STUDENTS PLANNING TO PLAY ON AN NCAA TEAM		
Personal Health History—Have you ever had:	**No/Never**	**If yes, provide description and dates if known.**
Head injury/concussion		
Significant injury or fracture		
Asthma or breathing problem Do you have an inhaler?		
Unexplained seizure When?		
Admission to hospital For what?		
Concern for body weight and/or size		
Age of first menstrual period		
Missed more than three consecutive periods in the past 2 years?		
Do you vape or smoke? What?		
Cardiac History		If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS
Chest pain, fainting, dizziness with exercise		
Excessive breathlessness		
Irregular heartbeat/arrhythmia/palpitations		
Has anyone in your immediate biological family had:		If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS
Sudden or unexplained death before age 50, seizure, or drowning		
Heart problem/ heart attack		
Diabetes, asthma, cancer or seizures		
High blood pressure or blood clots		

Physical Exam	**Normal / Unremarkable**	**Findings:**
Appearance (Assess for Marfan Stigmata)		
Head/Ears/Eyes/Nose/Throat		
Lymph Nodes		
Cardiac Assessment: Performed seated, supine, squatting, & with Valsalva. Assess for murmurs.		
Pulses (Femoral /Radial/Pedal)		
Lungs		
Abdomen		
Skin (MRSA/HSV/Tinea)		
Neurologic: including reflexes & strength		
Psychiatric		
Musculoskeletal: Neck/ Back/ Spine		
Musculoskeletal: Extremities		
Musculoskeletal: Joints		
Vision: R L Corrected?		

All participating student-athletes are required to provide confirmation of sickle cell trait status, either through: 1) existing documentation from birth, or 2) recent screening. *If students are unable to access testing prior to arrival, labs can be completed at the Schacht Center. Lab fees and deductibles apply.*

☐ **I attest that student has negative sickle cell screening.**

☐ **Or a copy of the student's negative sickle cell testing is attached. (Provide copy of results).**

Please attach further notes as desired.

☐ **CLEARED FOR ALL ATHLETICS WITHOUT RESTRICTION**

☐ Not cleared for athletics: Advise further evaluation for _____
☐ EKG performed and attached. Referred to Cardiology: Name of Provider _____ Date of Appointment_____
☐ Cardiology clearance letter attached, if applicable.

I HAVE EXAMINED THE ABOVE-NAMED STUDENT. MY FINDINGS AND RECOMMENDATIONS ARE AS INDICATED ABOVE.

Provider Name **M.D./ D.O. N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

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Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.