Medical History Form

American International College | Dexter Health Services | 1000 State Street, Box 55, Springfield, MA 01109 | Phone 413-205-3248 | Fax 413-205-3512

FIRST NAME MIDDLE LAST NAME				Gender ☐ M ☐ F ☐ Other _____
DATE OF BIRTH (MM-DD-YY)	CELL PHONE		HOME PHONE	
MAILING ADDRESS – STREET	CITY	STATE	ZIP	COUNTRY
EMERGENCY CONTACT NAME	RELATION TO STUDENT	HOME PHONE	CELL PHONE	
LIST ALLERGIES:	LIST PRESCRIPTIONS OR OVER-THE-COUNTER MEDICINES (include dose):			

PERSONAL HISTORY: Please check any that pertain to you. Explain positives in space below or attach additional comments.

Anxiety		Diabetes		Hernia		Seizures	
Asthma		Ear trouble/Hearing loss		High Blood Pressure		Sickle cell trait	
ADD/ADHD		Eating disorder		High cholesterol		Sinus problems	
Cancer		Eye trouble/Vision loss		Intestinal/Stomach trouble		Spleen (Surgical removal)	
Chest pain		Fractures (including stress)		Joint injury (sprain/dislocation)		Syncope/Fainting	
Concussion/Head injury		Genetic disorder		Kidney disease		Thyroid disease	
Depression		Headaches (recurrent)		Mononucleosis		Tobacco use	
Other Health Conditions:							
List past Surgeries/surgical procedures:							

FAMILY MEDICAL HISTORY: Please list medical conditions, diseases, cancers or severe illness if any:

Father		Brothers	
Mother		Sisters	

You must complete the following Tuberculosis Risk Assessment:

☐Yes ☐No Have you had close contact with anyone sick with infectious TB disease?

☐Yes ☐No Were you born in or lived in a country with an elevated TB rate? (includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe)

☐Yes ☐No Are you immunosuppressed (current or planned)? (includes HIV infection, organ transplant recipient, treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication)

If you answered ***YES*** to any of the TB questions above, you must provide proof of a negative IGRA TB blood test or treatment for latent TB.

STUDENT-ATHLETES must have sickle cell trait screening/solubility test. Please provide a copy of newborn screen or Hemoglobin S blood test results (Sickledex or hemoglobin solubility test). Attach results.
Date: ____/____/_____ Result: _____ Licensed provider name & signature _____

HEALTH SCIENCE STUDENTS must have two-step Tuberculin Skin Test (Mantoux). Attach results.
Step #1.) Date administered: ___/___/___ Date read: ____/____/____ Results: _____ mm induration
Step #2.) (placed 7-21 days after the first TST) Date administered: ___/___/___ Date read: ____/____/____ Results: _____ mm induration
or QuantiFERON-TB Gold Date: ___/___/___ Result: _____ Licensed provider name & signature _____

*CONSENT FOR TREATMENT In case of serious illness or accident, I give AIC Dexter Health Services (DHS) or its representative(s) permission to secure medical and/or surgical care deemed necessary for my good health. I authorize DHS to perform and provide medical care as deemed necessary by licensed personnel. Also, I have read the HIPAA Notice of Privacy Practices disclosing how DHS may use and disclose my protected health information and accept the terms and conditions.

Student Signature (parent or legal guardian if student is under 18) _____Date _____

Upload your completed forms to your AIC Patient Portal by visiting https://aic.medicatconnect.com/

Physical Examination and Immunization Form

To be completed by a licensed health care provider

Student's Name: _____ **Date of Birth**: _____

Height ____ Weight ____ BP _____ Pulse _____ Vision R 20/ L 20/ Corrected: Y N

	√ Normal	Abnormal (explain)
Skin		
Eyes, Head, Ears, Nose, Throat		
Respiratory		
Cardiovascular		
Gastrointestinal/Hernia		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neurological, Psychiatric		
Other Significant Abnormalities		

Is there any reason this student should not participate in sports or clinical fieldwork? ☐Yes ☐No
Specify:

Do you have any recommendations regarding the care of this student? Specify ☐Yes ☐No

Is the patient under treatment for emotional or psychological conditions? Specify ☐Yes ☐No

Please complete the following or attach a copy of the Student's Immunization Records and/or Laboratory Evidence of Immunity:

Tdap (Tetanus-Diphtheria-Pertussis) (given within the last 10 years) MM/DD/YY _____

MMR (2 doses) Vaccine #1 (given on or after the 1st birthday) MM/DD/YY _____
MMR Vaccine #2 (given ≥ 28 days after first dose) MM/DD/YY _____

Hepatitis B (3 doses) Vaccine #1 MM/DD/YY _____
Hepatitis B Vaccine #2 MM/DD/YY _____
Hepatitis B Vaccine #3 MM/DD/YY _____

Varicella (2 doses) Vaccine #1 (given on or after the 1st birthday) MM/DD/YY _____
Varicella Vaccine #2 (given ≥ 28 days after first dose) MM/DD/YY _____

Meningococcal (MenACWY) (given on or after the student's 16th birthday) MM/DD/YY _____
Meningococcal B Vaccine (strongly recommended) MM/DD/YY _____

Provider's Name: _____ ☐MD ☐DO ☐NP ☐PA Facility's Address: _____

Provider's Signature: _____ Phone _____ **Date of Examination** _____