McDANIEL COLLEGE

The Wellness Center
Winslow Center
2 College Hill
Westminster, MD 21157
410-857-2243 Fax 410-857-2703
mmoxley@mcdaniel.edu

OFFICE USE ONLY:

Date Received:_____

Student ID #: _____

☐ Housing ☐ Commuter

ALL FULL TIME STUDENTS

Student Health Forms must be completed and returned by **July 15th for Fall** entrance, and **Jan 2nd for Spring** entrance. Forms can be mailed, faxed or emailed to: mmoxley@mcdaniel.edu.

GENERAL INFORMATION

Name:_____ Social Security No. _____
Last First Middle

Address:_____
Number and Street City State Zip Code

Home Phone: _____ Cell Phone: _____
Area Code Area Code

Date of Birth: ____/____/____ College Email: _____

Biological Sex: ☐ Male ☐ Female Gender Identity: _____ Preferred Name: _____

Term Entering: ☐ Fall _____ ☐ Spring _____ ☐ Transfer _____
Year Year Year

NOTIFY IN CASE OF EMERGENCY

Name 1: _____ Relationship: _____

Home Phone: _____ Work or Cell Phone: _____

Name 2: _____ Relationship: _____

Home Phone: _____ Work or Cell Phone: _____

CONSENTS

RELEASE OF MEDICAL RECORD INFORMATION

I hereby authorize McDaniel College to disclose information on the health forms to any Health Care Provider who has rendered medical services to me.

_____ Date _____
Student Signature

_____ Date _____
Parent/Legal Guardian Signature, if student is under 18 years of age.

PARENTAL CONSENT FOR MEDICAL TREATMENT OF MINOR (Younger than 18 upon arrival on campus):

I hereby authorize my son/daughter to be treated in the McDaniel College Wellness Center if needed, and in case of emergency and in the event that I am unavailable, to be taken to the nearest emergency care center or hospital for treatment.

_____ Date _____
Parent/Legal Guardian Signature, if student is under 18 years of age.

Last Name _____ First Name _____ MI _____ DOB _____

INSURANCE INFORMATION

ALL students are required to have health insurance. McDaniel College offers students the option of purchasing a comprehensive Student Health Insurance Plan. If you currently have health insurance coverage and would like to waive the option of purchasing the Student Health Insurance plan, please waive the policy by **September 15th** by completing the waiver form found at www.studentplanscenter.com . If you do not complete the online waiver to provide proof of health insurance coverage, the charge for the College's student health insurance policy will be applied to the tuition account. A student will need to waive the insurance each year that they are enrolled in McDaniel College.

Which insurance will you utilize? ☐ Private Insurance ☐ McDaniel College Student Health Insurance Policy

INSURANCE CONTINUED:

Insurance Company _____ Name of Policy Holder _____

Insurance Policy Number _____ Group Number _____

Address to send claims _____

INSURANCE CARD INFORMATION: Please attach a copy of your Insurance Card (front and back)

Personal Medical History: Please check all that apply and explain below (attach additional sheets if necessary)

ADD/ADHD		Cancer		GYN/Menstrual		Mononucleosis		Sickle Cell	
AIDS/ARC/HIV +		Celiac Disease		High Blood Pressure		Major Surgery		Sinus Problems	
Allergies		Concussion/Head Injury		Hearing loss		Migraines		Skin Disorders	
Anemia		Depression		Heart Murmur		Neck Injury		Smoker	
Anxiety Disorder		Diabetes		Hepatitis		Obesity		Seizures	
Asthma		Dizzy/Fainting		Hospitalizations		Peptic Ulcers		Tuberculosis	
Back problems		Eating disorders		Hypoglycemia		Pneumonia		Thyroid Disorder	
Bleeding Disorders		Fractures/Dislocations		Irritable Bowel		Rash/Hives		Vision problems	
Bronchitis		Gallbladder Disease		Kidney Disease		Rheumatic fever		**None Applicable**	

Comments

_____

_____

_____

ALLERGIES

☐ No Known Drug Allergies

☐ Drug Allergies (Specify) _____

☐ Other Allergies (Specify) _____

Does Patient Carry an Epi-Pen? Yes/No (circle one)

Medications: List all medication taken on a regular or frequent basis. Please include birth control pill, nonprescription medication, vitamins, herbs and supplements.

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

Drug: _____ Dose: _____ Drug: _____ Dose: _____

PHYSICAL EXAM/IMMUNIZATIONS/TB SCREENING

MUST BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. YOUR HEALTH CARE PROVIDER MUST UPDATE IMMUNIZATIONS TO MEET THE COLLEGE REQUIREMENTS.

PHYSICAL EXAM: To be completed by physician, physician's assistant or nurse practitioner no more than twelve months prior to college entrance.

Name _____ Date of Exam: ___/___/___ Height: _____ Weight: _____ BP: _____

Examination Findings (Describe fully. Use additional sheets if necessary)

	Normal	Abnormal	Findings (please describe)
Skin			
Head, Ears, Nose and Throat			
Eyes			
Respiratory			
Cardiovascular			
Gastrointestinal			
Neurologic			
Musculoskeletal			
Metabolic//Endocrine			

REQUIRED Immunizations and Dates: Please attach a copy of all immunizations

Immunization	Date	Immunization	Date
Tetanus/Tdap (Please circle) (within the last 10 years)	___/___/___ Mo. Day Yr.	Hepatitis B #1	___/___/___ Mo. Day Yr.
Polio Series	□ Yes □ No	Hepatitis B #2	___/___/___ Mo. Day Yr.
MMR #1	___/___/___ Mo. Day Yr.	Hepatitis B #3	___/___/___ Mo. Day Yr.
MMR #2	___/___/___ Mo. Day Yr.		
Chickenpox Vaccine #1	___/___/___ Mo. Day Yr.	Chickenpox Vaccine #2	___/___/___ Mo. Day Yr.
Varicella Titer OR Doctor Documented Date of Disease	___/___/___ Mo. Day Yr.	Meningococcal Vaccine **(or waiver signed below)**	___/___/___ Mo. Day Yr.

Meningococcal Vaccine Waiver: I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is a rare but life threatening illness. I understand that Maryland Law requires that an individual enrolled in an institution of higher learning in Maryland who resides in on-campus housing shall receive the vaccination against meningococcal disease unless the individual signs a waiver to the vaccination. I choose to waive receipt of meningococcal vaccine. (Sign Below)

Student Signature_____Date _____

Parent/Legal Guardian Signature, if student is under 18 years of age. _____

Restrictions for Physical Activity (PE, Intramural Sports, ROTC): □ Yes □ No

Explain: _____

Is the student now under treatment for any medical or emotional condition that requires special housing? □ Yes □ No

Explain: _____

_____

If Yes, the student MUST complete the **Special Housing Considerations Request Form**, which can be found on the College's website.

Clinician Signature: _____ **Address**: _____

Print Name: _____ _____

Date: _____ **Phone #:** _____ _____

McDaniel College TB Screening Questionnaire

ALL STUDENTS MUST COMPLETE THE TB SCREENING QUESTIONNAIRE FORM AND OBTAIN YOUR CLINICIAN'S SIGNATURE

Part I Name _____ Date _____

1. Have you ever had a positive Tuberculin skin test (PPD)? Yes ___ No ___ Uncertain ___

If Yes, please indicate date and where testing was performed _____

2. Have you ever had a BCG vaccination? Yes ___ No ___ Uncertain ___

If Yes, please indicate the date and where vaccination was given _____

3. Have you ever had close contact with persons known or suspected to have active TB infection? Yes ___ No ___

4. Were you born outside of the United States? Yes___ No ___

If Yes, please specify the country where you were born _____

Dates of residence: From _____ to _____

5. Have you traveled and/or lived outside of the United States? Yes ___ No ___

If Yes, please indicate below:

Country	Year	Length of Stay

6. Have you been a resident/volunteer/employee of a high-risk setting (correctional facility, long-term care facility, homeless shelter)? Yes ___ No ___

7. Have you ever been a member of any of the following groups that may have an increased incidence of TB disease – medically underserved, low-income, or abused drugs or alcohol? Yes ___ No ___

8. Do you have any of the following symptoms?

	YES	NO		YES	No
Cough lasting 3 weeks or more			Unexplained weight loss		
Coughing up blood			Night sweats		
Chest pain			Fever		
Loss of appetite					

IF the answer is YES to any of the above questions, McDaniel College requires that you receive TB testing prior to the start of the subsequent semester. If you are an international student, it is required that you have a TB test performed in the United States within 12 months of entering McDaniel College. For US residents, testing is done at the discretion of your clinician.

PPD Date Given: _____ Date Read: _____ Result: _____mm Positive/Negative

(If greater than 10mm Induration, Chest X-ray or QFT is required)

Date of Chest X-Ray/ QFT: _____ Result: _____

Treatment Dates: _____ Medication: _____

_____ _____

Student Signature Date

_____ _____

Clinician Signature Date