Simmons University Health Center
94 Pilgrim Rd. Boston, MA 02215
Tel. 617-521-1020 Fax 617-521-3467

Name_____ Date of Birth_____ ID#_____

Due dates: July 15 for fall classes and January 10 for spring classes

Entrance date: _____ First-year_____ Sophomore_____ Junior_____ Senior_____ Dix_____

Entrance Health Certificate

To be completed by the student

Do you plan to play a sport? ___No ___Yes Name of sport: _____

All athletes are required to have a pre-participation sports physical at the Simmons College Health Center.

Permanent Address: _____
Street City State Zip Country

Cell Phone _____ Home Phone _____

Parent/Guardian Information/Emergency Contact

Name _____ Relationship: _____

Address and telephone if different from above:

_____
Street City State Zip Country

Cell Phone _____ Alternate Phone_____

Alternate Emergency Contact Information

Name _____ Relationship: _____

Cell Phone_____ Alternate phone_____

Insurance Information

☐I plan to be covered by the College insurance plan

☐I plan to be covered by: Name of insurance company: _____

Policy Number_____ Name of Policy Holder_____

Permission for Medical & Emergency Treatment for Students under 18

Must be completed by parent or legal guardian – not required for students 18 years or older

Name of student_____

Medical treatment: This is to certify that permission is granted to Simmons College Health Center to provide medical treatment for illness, injury or required immunizations for the above-named student.

Signature of parent or legal guardian_____

Emergency treatment: permission for emergency treatment (including surgery & anesthesia) is granted for above named student, when parent or guardian is unable to be contacted.

Signature of guardian_____

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Student Health History

To be completed by your healthcare provider

Name_____

Date of Birth_____ Simmons Student ID #_____

List any significant past or current medical, surgical or psychiatric conditions:
_____
_____
_____
_____
_____

List any current medications/dosage:
_____
_____
_____
_____

List any medication allergies:
_____

Is the student able to fully participate in sports? ☐Yes ☐No

If no, please explain._____
_____

Clinician's Signature_____

Clinician's Printed Name _____

Telephone_____

Date_____

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Tuberculosis Risk Assessment

Required for All Undergraduate and Graduate Students

Have you had close contact with anyone who was sick with tuberculosis (TB)? ❑Yes ❑ No

Where you born in a country with high rates of TB (see list below)? ❑ Yes ❑ No

Have you traveled or lived for more than a month in one of the countries with a high rate of TB? ❑ Yes ❑ No

If you have answered NO to all the questions, no further testing is required. Please submit this form to the Simmons College Health Center.

If you answered YES to any of the above questions, either a PPD test (Mantoux) OR Interferon Gamma Release Assay (IGRA) must be completed by your Health Care Provider within 12 months prior to entering Simmons College.

PPD (Mantoux) Test:

Date Read: _____ (mm/dd/yy) **OR**

Results: (in mm of induration):_____mm
(10 mm or more is positive-Chest X-ray needed)

IGRA DATE: _____ (mm/dd/yy)

Result (circle): **Positive Negative**

Chest X-ray required if PPD is positive (10mm or more), **OR** if IGRA is positive

Date Performed: _____(mm/dd/yy)

Results (circle) **Positive Negative**

Has this patient been treated for a positive PPD? ❑NO ❑**YES Describe**: _____

Signature of Health Care Provider_____

Print Signature Date

Afghanistan	Congo DR	Kenya	New Caledonia	Sri Lanka
Algeria	Cote d'Ivoire	Kiribati	Nicaragua	Sudan
Angola	Croatia	Korea-DPR	Niger	Suriname
Anguilla	Djibouti	Korea-Republic	Nigeria	Syrian Arab Republic
Argentina	Dominican Republic	Kuwait	Niue	Swaziland
Armenia	Ecuador	Kyrgyzstan	N. Mariana Islands	Taiwan
Azerbaijan	Egypt	Lao PDR	Pakistan	Tajikistan
Bahamas	El Salvador	Latvia	Palau	Tanzania-UR
Bahrain	Equatorial Guinea	Lesotho	Panama	Thailand
Bangladesh	Eritrea	Liberia	Papua New Guinea	Timor-Leste
Belarus	Estonia	Lithuania	Paraguay	Togo
Belize	Ethiopia	Macedonia-TFYR	Peru	Tokelau
Benin	Fiji	Madagascar	Philippines	Tonga
Bhutan	French Polynesia	Malawi	Poland	Tunisia
Bolivia	Gabon	Malaysia	Portugal	Turkey
Bosnia & Herzegovina	Gambia	Maldives	Qatar	Turkmenistan
Botswana	Georgia	Mali	Romania	Tuvalu
Brazil	Ghana	Marshall Islands	Russian Federation	Uganda
Brunei Darussalam	Guam	Mauritania	Rwanda	Ukraine
Bulgaria	Guatemala	Mauritius	St. Vincent &	Uruguay
Burkina Faso	Guinea	Mexico	The Grenadines	Uzbekistan
Burundi	Guinea-Bissau	Micronesia	Sao Tome & Principe	Vanuatu
Cambodia	Guyana	Moldova-Rep.	Saudi Arabia	Venezuela
Cameroon	Haiti	Mongolia	Senegal	Viet Nam
Cape Verde	Honduras	Montenegro	Seychelles	Wallis & Futuna
Central African Rep.	India	Morocco	Sierra Leone	W. Bank & Gaza Strip
Chad	Indonesia	Mozambique	Singapore	Yemen
China	Iran	Myanmar	Solomon Islands	Zambia
Colombia	Iraq	Namibia	Somalia	Zimbabwe
Comoros	Japan	Nauru	South Africa	
Congo	Kazakhstan	Nepal	Spain	

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Undergraduate Immunization Form

Entrance Date_____

Required Vaccines/Titers: (Provider immunization form may be substituted)

Vaccine	Date 1	Date 2 (or results)	Date 3
MMR (2 doses) OR			
Measles Titer		☐**Immune** ☐**Not Immune**	
Mumps Titer		☐**Immune** ☐**Not Immune**	
Nursing Requirement **Rubella Titer**		☐**Immune** ☐**Not Immune**	
Hepatitis B (3 doses) AND			
Nursing Requirement **Hepatitis B Titer (Anti-HB abs)**		☐**Immune** ☐**Not Immune**	
Meningitis (MCV4) **On or after 16th birthday**			☐**Signed waiver**
Tdap (1) then Td every 10 years		**Td**	
Varicella (2 doses) OR			
Varicella Titer		☐**Immune** ☐**Not Immune**	
Additional Requirement	**Dose #1**	**Dose #2**	**Booster Dose**
Moderna/Pfizer Covid-19			
Janssen Covid-19			

Additional requirements for Nursing Students:

Blood work showing immunity to Rubella and Hepatitis B are required for clinical placement even with evidence of 2 MMR and 3 Hepatitis B vaccines.

Clinician's Signature_____Telephone_____Date_____