Medical History Form

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 or disease	
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	

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.

*CONSENT FOR TREATMENT I consent to evaluation, diagnosis, and treatment at American International College (AIC) Dexter Health Services (DHS) by licensed healthcare professionals, including physician assistants and other qualified staff. I authorize DHS to provide medical care as clinically appropriate. If my condition requires services beyond those available at DHS, I authorize referral and/or transfer to an appropriate facility for further evaluation or treatment. I acknowledge that I have received or have access to the Notice of Privacy Practices in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and understand how my protected health information may be used and disclosed.

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 & Immunization Form

To be completed by a licensed health care provider (MD, DO, PA or NP)

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

Height: _____ Weight: _____ BP _____ Pulse _____

Vision: R 20/____ L 20/_____ ☐ Corrected (glasses/contacts)

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

Medical Assessment & Clearance

Does the student have any health condition(s) that may impact safe participation in:

- Sports ☐ Yes ☐ No
- Clinical fieldwork ☐ Yes ☐ No

If yes, please specify condition(s) and functional impact:

_____

_____

Clearance Status

☐ Cleared for all activities without restriction

☐ Cleared with restrictions (specify):

_____

☐ Not cleared (explain and include follow-up plan):

_____

_____

Provider Attestation: I have examined this patient and certify that, based on this evaluation, they are medically able to participate in the activities indicated above.

This determination is based on the patient's condition at the time of examination. Additional evaluation or program-specific requirements (e.g., athletics or clinical placements) may apply. Any significant change in health status should be re-evaluated by a licensed medical provider. Final determination of participation and any required accommodations is made by the college and/or applicable program.

Provider's Name: _____ Provider's Signature: _____

Credentials: ☐MD ☐DO ☐NP ☐PA

Facility's Address: _____Phone: _____

Date of Physical Examination: ____ / ____ / _____

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Physical Examination & Immunization Form

To be completed by a licensed health care provider (MD, DO, PA or NP)

Student Immunization Record

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

Instructions:
Please complete the following information **or attach an official copy of the student's immunization records and/or laboratory evidence of immunity.**

Massachusetts Required Immunizations

Tdap (Tetanus, Diphtheria, Pertussis)

- **Date (within last 10 years):** ____ / ____ / _____

Requirement: 1 dose within the last 10 years

- *Note: DTaP or Td alone do not meet this requirement*

MMR (Measles, Mumps, Rubella) – 2 Doses

- **Vaccine #1:** ____ / ____ / _____
- **Vaccine #2:** ____ / ____ / _____

Requirement: 2 doses (first dose on or after 1st birthday; second dose at least 28 days after first)
OR positive blood titers demonstrating immunity

Hepatitis B – 3 Doses

- **Vaccine #1:** ____ / ____ / _____
- **Vaccine #2:** ____ / ____ / _____
- **Vaccine #3:** ____ / ____ / _____

Requirement: 3-dose series
OR positive blood titer (lab evidence of immunity)
OR 2 doses of Heplisav-B given at age 18 or older

Varicella (Chickenpox) – 2 Doses

- **Vaccine #1:** ____ / ____ / _____
- **Vaccine #2:** ____ / ____ / _____

Requirement: 2 doses (first dose on or after 1st birthday; second dose at least 28 days after first)
OR documented history of disease by a medical provider
OR positive blood titers demonstrating immunity

Meningococcal (MenACWY)

- **Date:** ____ / ____ / _____

Requirement: 1 dose required for all full-time students age 21 or younger. Dose must be given on or after the 16th birthday

- *Note:* Doses given before age 16 do not meet requirement.

Students may decline after reviewing and signing the Massachusetts Department of Public Health Meningococcal Information and Waiver Form

Meningococcal B Vaccine (Recommended)

- **Date:** ____ / ____ / _____

Provider Attestation

I have reviewed this student's immunization record and certify that it is accurate and complete to the best of my knowledge.

Provider's Name: _____ **Provider's Signature:** _____

Date: ____ / ____ / _____

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