

SIMMONS COLLEGE
ENTRANCE HEALTH CERTIFICATE

Simmons College Health Center, 94 Pilgrim Road, Boston, MA 02215
Telephone (617) 521-1020 Fax (617) 521-3467

Students: please complete pages 1-6

Health Care Provider: Please review pages 2,3, and complete immunization pages

Entrance date: _____ Freshman _____ Sophomore _____ Junior _____ Senior _____ Dix _____

Name _____ Date of Birth _____ / _____ / _____
Last First Middle Month Day Year

Social Security # _____ - _____ - _____ Female _____ Male _____

Home Address _____
Number Street City State Zip Country

Home Telephone _____ Cell Phone _____
Area Code Number Area Code Number

Mother's Name _____ Occupation _____ Work Phone _____

Address, home phone if different from above _____
Address Home Phone

Father's Name _____ Occupation _____ Work Phone _____

Address, home phone, if different from above _____
Address Home Phone

Emergency Contact if Parent not available: Name _____
Telephone _____ Relationship _____

Insurance Information:

- I plan to be covered by school insurance
- I will be covered by;
Name of Insurance Company _____
Policy Number _____
Name of Policy Holder _____
Social Security Number of Policy Holder _____
Does your insurance company require prior approvals for specialty referrals? Yes ___ No ___
If yes, contact name and telephone number _____

TO BE COMPLETED BY STUDENT

MEDICAL HISTORY (1)

To be completed by student/family and reviewed by Health Care provider

Check any items that apply. Comment on all checked items in space below.

Have you had or do you have	Yes	No		Yes	No
1. asthma			20. chest pains or shortness of breath during or after exercise		
2. absence of any organ(s)			21. racing heart, palpitations or skipped heart beats		
3. anemia			22. fainting during or after exercise		
4. bladder or kidney disease			23. neck injury or "stinger" (pins and needles) in one or both arms after being hit in head or neck		
5. cancer			24. heat related illness		
6. diabetes			25. sprain, dislocation, fracture or other significant injury of:		
7. heart murmur /other cardiac problem			head/neck		
8. hemophilia			chest/back		
9. high blood pressure			arm/hand/shoulder/elbow/wrist		
10. HIV infection			hip/thigh/knee		
11. other major infection			calf, ankle, foot		
12. Marfan Syndrome			26. ongoing diarrhea or blood in stool		
13. rheumatic fever			27. Have you been advised by physician to avoid contact sports?		
14. sickle cell disease or trait			28. Have you been described as "double jointed" ?		
15. seizure disorder			29. Do you use any protective equipment or braces during exercise?		
16. thyroid disease			30. Have you used steroids to improve athletic performance?		
17. tuberculosis			31. Do you smoke or use drugs?		
18. eating disorder			32. For women: # of menstrual periods in previous 12 months		
19. parent or sibling with any of the following medical problems: (circle) (a) heart disease or sudden cardiac death before 65 (b) cancer; (c)phlebitis; (d) bleeding disorder			32. For men: Any testicular problems?		

Students: Please comment on any "yes" items above. Refer to item by number.

For physician comments.

TO BE COMPLETED BY STUDENT

Medical History (2):

1. List any drug allergies: _____

2. List any chronic illness not already noted: _____

3. Have you ever been hospitalized? If yes, please specify reason.

4. Please list any prescription medications you are taking:

Name/dosage of medicine	Name and phone number of prescribing provider
_____	_____
_____	_____
_____	_____

5. Do you have any other health concerns you would like us to know about?

Note: To discuss any health concerns or questions, please contact the Health Center at (617) 521-1020. To discuss campus based counseling services or counseling referrals please feel free to contact the Simmons Counseling Center at 617-521-2455

Confidentiality Policy

The Health Center respects student confidentiality. The Health Center may share clinical information with other clinicians to facilitate patient care, but no health information is released to parents or College staff other than Health or Counseling center clinicians without the student’s express authorization except as required by law.

Permission for Medical & Emergency Treatment for Students under 18
Must be completed by parent or legal guardian

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 parent or guardian _____

In all cases, reasonable effort will be made to contact parent or guardian prior to treatment.

To Be Completed by Health Care Provider

Patient Name _____ Date of Birth _____

Please review student's medical history, pages 2, 3. Any comments?

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

List any current medications/dosage

List any medication allergies

Do you have any reservation about this student participating athletics or other school activities?

NO _____

YES _____ Explain _____

Name: _____
Health Care Provider

Signature _____

Telephone No _____

Date _____

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