FRAMINGHAM STATE UNIVERSITY

HEALTH CENTER
Foster Hall, Framingham, MA 01701-9101
http://framingham.medicatconnect.com
P: (508) 626-4900

ADMISSION HEALTH FORM

Name:_____ Date of birth: _____ FSU ID: _____

IMMUNIZATIONS *(to be completed by health care provider only).*

Massachusetts Law Requires Proof of the Following Immunizations:

1. Please have your health care provider complete this form or obtain their record of your completed immunizations.
2. Upload the completed immunization and physical exam forms (signed by your health care provider) to the Patient Portal: **framingham.medicatconnect.com**

MMR (Measles, Mumps, Rubella) **2 doses required** **Date**

☐ Dose 1 (Immunized on or after first birthday) _____
☐ Dose 2 (Given at least 4 weeks after Dose 1) _____
OR
☐ Serology results (TITERS) Measles_____ Mumps _____ Rubella _____
(Submit copy of lab report)

Tdap (Tetanus, Diptheria, Pertussis) **Date**

☐ Booster within last ten years _____

Hepatitis B

☐ Primary Series #1_____ #2_____ #3_____
(COMPLETED)
OR
☐ Hepatitis B Serology (TITER) Results_____
(Submit copy of lab report)

Varicella Vaccine (Chicken Pox) **Date**

☐ Dose 1 (Immunized on or after first birthday) _____
☐ Dose 2 (Given at least 4 weeks after Dose 1) _____
OR
☐ Serology (TITER) results _____
(Submit copy of lab report)
OR
☐ Chickenpox disease (self report with review by healthcare provider) _____

Meningococcal Vaccine: (Applies to newly enrolled fulltime residential students ONLY) **Date**

☐ Received Vaccine (Menactra, Menveo, Menomune, MCV4) _____
OR
☐ Signed Waiver (enclosed) _____

Covid-19 vaccine: Recommended 1 Dose of UPDATED BIVALENT

Date	**Date**	**Date**
Pfizer _____	Moderna _____	Other _____

_____ _____
Signature of Health Care Provider Address

Name:_____ Date of birth: _____ FSU ID: _____

PHYSICAL EXAMINATION

A PHYSICAL EXAMINATION WITHIN THE PAST 18 MONTHS IS REQUIRED.

Date of Exam: _____

ABNORMALITIES:

No.	System	Yes	No	List number and describe abnormality
1.	Skin			
2.	HEENT			
3.	Neck, thyroid			
4.	Chest, lungs			
5.	Breasts			
6.	Heart			
7.	Abdomen			
8.	Genitalia			
9.	Musculoskeletal			
10.	Neurological			
11.	Psychological			
12.	Neurological			

Height:_____ **Weight:** _____**BMI:** _____ **Pulse:** _____ **BP:**_____

CURRENT MAJOR AND CHRONIC PROBLEMS:

_____

_____

ACUTE OR MINOR PROBLEMS:

_____

_____

IF THE STUDENT IS UNDER CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

Hospitalizations: _____ Surgeries: _____

Reason and Date: _____ Type and Date: _____

I have known applicant for_____years.

ALLERGIES (medications, foods, insect, venom): _____

Type of reaction:_____

CURRENT MEDICATIONS (include vitamins, OTCs, contraceptives): _____

_____

POTENTIAL ATHLETES: Students are NOT eligible to practice or participate in intercollegiate, varsity or club sports until this form has been completed and submitted to the Health Center.

RECOMMENDATIONS FOR PHYSICAL ACTIVITY:

* CHECK ONE *

☐ **Collision:** *Hockey, Football, Rugby, Cheerleading, Men's Lacrosse*

☐ **Contact:** *Women's Lacrosse, Baseball, Basketball, Soccer, Softball, Baseball, Field Hockey, Volleyball*

☐ **Non-Contact:** *Cross Country*

Health Care Provider (please print): _____

Address: _____

Phone: _____ FAX: _____

Provider's Signature:_____ Date of Exam: _____

Framingham State University Tuberculosis (TB) Medical Provider Form

STEP 1. Complete the ON-LINE "TB SCREENING QUESTIONNAIRE" IN MEDICAT

If you answered **"NO"** to all items on TB Screening Questionnaire STOP **do not complete this form.**

If you answered **"YES"** to any items on TB Screening Questionnaire, **a healthcare provider must complete this form.**

Name (first):_____ (Last):_____ Student ID #:_____

Date of Birth (Month/Day/Year):_____ Phone Number:_____

STEP 2. Tuberculin Skin Test (TST), or a TB blood test (QuantiFERON Gold or T-Spot) must be performed within 6 months of enrollment.
*** If a TST has been previously done and resulted "positive", skip to Step 3.**

TST Plant date:_____ Read date*:_____ Result:_____ mm of induration ☐ Positive ☐ Negative

or

of QuantiFERON Gold or T-Spot _____ *Result: ☐ Positive ☐ Negative

*If blood test is POSITIVE, Skip to STEP 4. **Must provide the actual lab results from the laboratory testing facility.

STEP 3. If *POSITIVE* Tuberculin Skin Test in Step 2, Blood Testing for TB is required:

Date of QuantiFERON Gold or T-Spot Blood Test:_____ *Result: ☐ Positive ☐ Negative

*Must provide the actual lab results from the laboratory testing facility.

STEP 4. If *POSITIVE* blood testing in Step 2 or 3, a Chest X-ray is required:

Date of Chest X-ray:_____ Result: ☐ Normal ☐ Abnormal *(Attach Report, NOT the X-ray)

Clinical Evaluation: _____ Normal _____ Abnormal

Describe: _____

Clinical Evaluation: _____No _____Yes If Yes, Drug/s, dose frequency, and dates: _____

Treatment: _____

Health Care Provider

Name:_____ Signature:_____

Date:_____ Phone Number:_____

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