Eastern Nazarene College

HEALTH FORM INSTRUCTIONS

All students, commuter and residential, online and remote, who attend ENC full time are required to complete the Student Health Form. Parts A, B, and E are to be completed by the student. Parts C and D (and if necessary Part F) must be completed by a doctor, physician's assistant, or nurse practitioner.

GETTING STARTED:

Get started early – This allows time for Health Services to assess your documentation and to inform you if anything is incomplete or missing. Sometimes there are problems with medical records and starting early gives you more time to deal with the issues. You do not have to submit everything at once.

Begin with your immunization record – We strongly encourage you to call your doctor **as soon as possible** and have your immunization record faxed to 617-745-3928, Attn: Patsy Malas – Director of Health Services. When we check it, we will inform you if anything is still needed. If Health Services receives your immunization record well in advance, then it can be assessed before your physical exam and you can get any missing vaccines while you are at the doctor's office. If you are unable to have us assess your immunization record ahead of time, make sure that every required vaccine is documented and given within the proper dates.

COMPLETING YOUR HEALTH FORM:

PART A – STUDENT INFORMATION AND SIGNATURES

Fill in all the required information for each section and be sure to sign and date on all the requested signature lines. You should have at least **two signatures** on this page. **If you are under 18**, then **a parent must also sign**.

PART B – MEDICAL HISTORY

Fill in all the required information for each section. **Check YES or NO** for each item, in each column, and **answer every question**.

PART C – PHYSICAL EXAMINATION

This form must be signed and dated by your health care provider. You are required to have a physical exam **within one year. If you are an athlete**, the NCAA requires that you have a physical exam **within six months**. If you have had a physical within one year prior to starting classes, print out Part C of the Student Health Form and have your doctor or nurse practitioner complete it, based on that physical. If you need a physical exam, take Part C with you and ask the doctor or NP to complete it.

PART D – IMMUNIZATION RECORD

You may submit either a copy of your immunization record or *Part D, Immunization Recor*d, signed and dated by a health care provider. You must have appropriate documentation for every required vaccine.

In addition, ENC is requiring all students, both commuter and residential, to be vaccinated against COVID-19 prior to returning to campus this Fall. This is a new requirement that is not yet listed on the immunization form.

PART E – TUBERCULOSIS RISK QUESTIONNAIRE

Answer each question on *Part E, Tuberculosis Risk Questionnaire.*

If the answer to ALL of questions 1-6 is NO, then a TB test is NOT NEEDED and no further action is required.

If the answer to ANY of questions 1-6 is YES, then you are required to provide documentation of a TB test, and to have your health care provider complete *Part F, Medical Evaluation for Latent Tuberculosis Infection.* The TB test must be completed within 6 months prior to entrance into ENC, unless you have had a previous positive TB blood test (IGRA). If you have had a positive TB skin test in the past, then you must submit either documentation of treatment for Latent Tuberculosis or results of a TB blood test (IGRA).

PART F – MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

This form is **ONLY REQUIRED** if you answered **YES** to any one of questions 1-6 on **Part E**.

Continues next page

HEALTH INSURANCE:
You will need to **review the Health Insurance requirements** at universityhealthplans.com and **identify** whether you **need to enroll** in the yearly Student Health Insurance Plan, or if you are **eligible to waive**. If you wish to waive out of the Student Health Insurance Plan, you are responsible to determine if your insurance plan provides coverage to be treated by medical providers in the Quincy area, and if it is comparable to the Student Health Insurance Plan. An insurance plan with coverage only at an Urgent Care Center or an Emergency Room in the Quincy area is not acceptable. If you live outside of Massachusetts, it is highly recommended that you call member services for your insurance provider and ask about your coverage in this area before you decide to waive the insurance.

Once you have evaluated your insurance options, you need to **either Enroll in or Waive** the yearly Student Health Insurance Plan by completing the form at universityhealthplans.com. Please be aware that a waiver may be reviewed and, if your insurance does not meet the acceptable criteria, the waiver will be denied. You will then be automatically enrolled in and billed for the Student Health Insurance Plan.

DEADLINES:

Fall Semester – July 31

Spring Semester – December 1

If Health Services does not receive all your required documentation before the semester starts, you will be placed on Medical Probation. If your requirements are still incomplete on October 1 (fall semester) or February 15 (spring semester), **you will be given a $250.00 late fee.**

SUBMITTING YOUR HEALTH FORM:

Health Forms may be **FAXED** to: 617-745-3928, Attention: Patsy Malas – Director of Health Services, or **MAILED** to: Eastern Nazarene College Health Services, 23 E. Elm Avenue, Quincy, MA 02170.

We suggest making a copy of the Student Health Form for your records.

Watch your ENC email – Each time your documentation is received and processed by Health Services, confirmation will be sent to your ENC email to inform you that it was received and to give you details of anything that is missing.

QUESTIONS:
If you have any questions about health requirements, please email Health Services, at **healthservices@enc.edu**. Health Services is closed during the summer; however, someone will be in the office about every two weeks to check email and health records, and then we will respond to any questions or issues you may have.

Please Note

All Full-time students must complete and **return this form to Health Services.**

Deadlines
Fall Semester - July 31
Spring Semester - December 1

Any student failing to provide the required documentation by Move-in Day will be placed on Medical Probation.

A $250.00 Late Fee will be assessed if these requirements are not met by Oct. 1 for Fall Semester or Feb. 15 for Spring Semester.

Eastern Nazarene College

HEALTH FORM

HEALTH SERVICES

23 East Elm Ave.
Quincy, MA 02170
Telephone 617-745-3893
Fax 617-745-3928

OFFICE USE ONLY

Date Received:

Allergies or Flag Conditions:

All Requirements complete ❑

Semester Entering ENC: ________/_______

PART A

Student is to complete Parts A, B and E. Health care provider is to complete Parts C and D.
We suggest making a personal copy of this form before returning it.

STUDENT INFORMATION

Name: ____
Last First MI

Date of Birth: ______________________
Month Day Year

Permanent Address: ____
Street

Birthplace: ________________________
Country

____
City State/Country Zip/Postal Code

❑ Female ❑ Male

Home Phone: (________)_______________________________ **Cell Phone: (________)**________________________________

INSURANCE INFORMATION

You need to research your health insurance options to identify whether you need to enroll in the Student Health Insurance Plan, or if you are eligible to waive. Review the health insurance requirements at universityhealthplans.com.

- ❑ I have completed the research to determine if I need to enroll in or waive the Student Health Insurance Plan.
- ❑ I have completed the insurance enrollment or waiver form.
- ❑ I am aware that I still need to complete the insurance enrollment or waiver form.

CONSENT and RELEASE INFORMATION

When this form is complete it will become a part of your medical record and, as such, the information will be considered confidential. If your health status changes, while enrolled at ENC, you are required to provide updates to the Health Services Office.

IMPORTANT NOTICE ON THE RELEASE OF INFORMATION:
During your college stay, the Health Services Office may need to communicate important information pertaining to your health to the professional staff in the Office of Student Development, Office of Counseling and/or the Athletic Department. In order to be able to do that we must have your signature and date below.

I agree to this release. Date: ___________________

Student Signature ____

CONSENT FOR EMERGENCY TREATMENT
To be signed by parent/guardian if student is under 18.
I give permission for medical treatment for my son/daughter if an accident or illness should occur while he/she is a student at ENC. This includes referral to a local hospital, hospitalization, anesthesia and/or surgery should it be necessary and I am unable to be reached.

____
Parent/Guardian's name (Please print)

Relationship _______________________________________ Date ____________

Signature ____

I have reviewed all the information contained in this Health Form. It is true and accurate to the best of my knowledge.

Student Signature: ____ Date: _____/_____/_____

Parent Signature: ____ Date: _____/_____/______
(required if student is under 18)

PART B • MEDICAL HISTORY

Please check YES or NO for each item and answer every question.

Student's Name: ____ Date of Birth: ____/____/______

FAMILY HISTORY

Have any of your relatives had any of the following? If yes, please give relationship to you.

	Yes	No	Relationship		Yes	No	Relationship
Alcohol/Substance Abuse				High Blood Pressure			
Asthma, Allergy, Hay Fever				Kidney Disease			
Bleeding Disorder				Mental/Emotional Disorder			
Cancer				Migraines			
Diabetes				Stomach Disease			
Epilepsy/Seizure Disorder				Stroke			
Heart Disease				Other			

PERSONAL HISTORY

PLEASE EXPLAIN ALL POSITIVE ANSWERS. Include dates. If more room is needed, attach another sheet.
Do you have now or have you ever had:

	Yes	No		Yes	No		Yes	No
Acne/Skin Conditions			Deaf/Hearing Impairment			Learning Disability		
ADD/ADHD			Depression			Liver Disease		
Alcohol/Drug Issues			Diabetes			Lyme Disease		
Allergies (Environmental/Seasonal)			Dizziness/Fainting			Malaria		
Anemia			Ear, Nose, Throat Problems			Meningitis		
Anorexia Nervosa/Bulimia			Emotional/Mental Illness			Menstrual Problems		
Anxiety/Panic Attacks			Gall Bladder Disease			Migraines/Chronic Headaches		
Appendectomy			GERD (Gastro-Esophageal Reflux)			Mononucleosis		
Arthritis			Gynecologic Problem			Neuromuscular Disease		
Asthma			Head Injury			Pelvic Inflammatory Disease		
Autism Spectrum Disorder			Heart Disease /Problem			Pneumonia		
Back Injury or Problems			Hepatitis			Seizure Disorder		
Bipolar Illness			Hernia			Sickle Cell Disease		
Blind/Visual Impairment			High Blood Pressure			Sleep Issues		
Blood Clots			HIV Infection/Disease			Stroke		
Bone or Joint Problems			Hives			Thyroid Disease		
Cancer/Malignancy			Immune System Disorder			Ulcer/Stomach Problems		
Celiac Disease			Impaired Mobility/Paralysis			UTIs (Frequent/Recurrent)		
Chron's/Ulcerative Colitis/IBS			Kidney Disease/stones			Other		

PLEASE ANSWER EACH QUESTION BELOW COMPLETELY.

ALLERGIES: Do you have any known allergies? *(including medications, insect venoms, foods, etc.)* ❑ yes ❑ no

If yes please specify ____

What type of reaction? ______________________________ Do you carry an Epi-pen? ❑ yes ❑ no

MEDICATIONS: *Please list all medications you are presently taking including prescription, over-the-counter, vitamins, and herbal supplements.*____

____

HOSPITALIZATIONS/SURGERIES/MAJOR INJURIES/ACCIDENTS: *If any, please provide details including dates.* ______________

____

Do you have any after effects of illnesses or injuries? (Please list) ______________________

Have any limits been placed on your ability to perform physical exercise or sports participation? (Explain) ______________

Are you presently under treatment for any medical condition/problem? (Describe) ______________________

Do you have a chronic disease or ongoing medical condition? (Describe)______________________

Are you physically challenged or do you have a permanent disability? (Explain) ______________________

Have you received or are you now receiving counseling/therapy? When? ______________________

Is there anything else college health services should know about your medical history? ______________________

PART C • PHYSICAL EXAMINATION

The NCAA requires all ATHLETES to have a physical exam within 6 months.

Student's Name: ____________________ Date of Birth: ____/____/____

Weight ________ Height ________ BP ________ Pulse ________ Glasses ❑ Contacts ❑ Hearing aid ❑

SYSTEM	NORMAL	ABNORMAL (PLEASE DESCRIBE)
Appearance		
Skin		
HEENT		
Mouth, Teeth, Gingiva		
Lungs/Chest		
Breasts		
Cardiovascular		
Gastrointestinal		
Abdomen (rectal if indicated)		
Hernia		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Lab work recommended: Hgb/Hct ______ Cholesterol ______ LDL ______ HDL ______ Urine: Glucose ______ Protein ______ Blood ______

Sickle Cell Trait Status (Recommended for **ATHLETES**) ____________________

CURRENT MAJOR and CHRONIC PROBLEMS

____

____

____

ACUTE or MINOR PROBLEMS

____

____

____

ALLERGIES: *(Medications, insect venom, foods, etc.)* ____________________

Type of Reaction ____________________ Does the student have an Epi-pen? ❑ yes ❑ no

CURRENT MEDICATIONS: ____________________

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL ACTIVITY, I.E. PHYS. ED., INTRAMURALS, SPORTS:

❑ Unlimited - cleared for full participation **OR** ❑ Limited - not cleared for full participation (specify limits) ____________________

____

Do you have any dietary recommendations? ____________________

General appraisal of this student's health and emotional stability. ____________________

____

Do you have any recommendations regarding the care of this student?____________________

____

Do you know of any condition that will affect health or studies? ____________________

____

HEALTH CARE PROVIDER *(please print)* ____________________ Phone ____________________

Address ____________________ FAX ____________________

Provider's Signature ____________________ Date of Exam: ____/____/____

PART D • IMMUNIZATION RECORD

Student's Name: ____ Date of Birth: _____/_____/_____
Last First MI Month Day Year

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (PHYSICIAN, PA, NP, NURSE, OR SCHOOL HEALTH OFFICIAL) UNLESS THERE IS A COPY OF AN IMMUNIZATION RECORD ATTACHED.

All students must provide documentation of immunity for each required immunization listed below.
If titers are done, please include copies of laboratory reports.

REQUIRED IMMUNIZATIONS

MMR – Measles, Mumps, Rubella • *Required of all students unless born in the US before 1957*
Two doses required or a blood titer to show immunity to the disease

❑ **MMR Dose #1**: Date _____/_____/_____
Must be given after first (1st) birthday

❑ **MMR Dose #2:** Date _____/_____/_____
At least one month after first (1st) dose

OR Lab test proving immunity (attach lab reports)

Measles ❑ Immune – titer value __________ Date ____/____/____

Mumps ❑ Immune – titer value __________ Date ____/____/____

Rubella ❑ Immune – titer value __________ Date ____/____/____

Tdap TETANUS-DIPHTHERIA-PERTUSSIS • *Required of all students.*

❑ Tdap Date ____/____/____
Must be given after 7 years of age

HEPATITIS B • *Required of all Students*

❑ **3-dose series**

Hepatitis B Dose #1 Date ____/____/____

Hepatitis B Dose #2 Date ____/____/____
Must be at least 1 month after #1

Hepatitis B Dose #3 Date ____/____/____
Must be at least 2 months after #2 and 4 months after #1

OR Lab test proving immunity (attach lab report)

❑ Immune – titer value ________ Date: ____/____/____

VARICELLA-CHICKENPOX • *Required of all students unless born in the US before 1980*

❑ Varicella Dose #1 Date ____/____/____
Must be given after first (1st) birthday

❑ Varicella Dose #2 Date ____/____/____
At least one month after first (1st) dose

OR Lab test proving immunity (attach lab report)

❑ Immune – titer value _________ Date: ____/____/___

OR ❑ Reliable history of chickenpox disease
If this box is checked, this form can ONLY be signed by an MD, PA, or NP

MENINGITIS (A, C, W, Y) • *Required of all students 21 years of age or younger.*

❑ Meningitis A, C, W, Y Vaccine Date ____/____/____
Must be given on or after 16th birthday

OR

❑ DPH Waiver, if not immunized, must be signed and returned with this form.
Waiver can be downloaded at: https://enc.edu/app/uploads/2017/08/Meningococcal-waiver-10-2016.pdf

RECOMMENDED IMMUNIZATIONS

MENINGITIS B • *Optional*

❑ Meningitis B Dose #1 Date ____/____/____

❑ Meningitis B Dose #2 Date ____/____/____

HEALTH CARE PROVIDER *(please print)* ______________________________ Phone ______________

Address ____ FAX ______________

Provider's Signature ________________________________ Date of Exam: _____/_____/_____

PART E • TUBERCULOSIS RISK QUESTIONNAIRE

Student's Name: ______________________________ Date of Birth: _____/_____/_____

1. Have you ever had a positive tuberculosis test? ❑ Yes ❑ No
2. To the best of your knowledge have you ever had close contact with persons known or suspected to have active tuberculosis (TB) disease? ❑ Yes ❑ No
3. Were you born in one of the countries listed below? (If yes, please circle the country.) ❑ Yes ❑ No
4. Have you traveled or lived for more than one month in one or more of the countries listed below? (If yes, please check the country/ies.) ❑ Yes ❑ No
5. Have you been a resident and/or employee of any high-risk congregate setting (e.g., correctional facility, long-term care facility, or homeless shelter)? ❑ Yes ❑ No
6. Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease? ❑ Yes ❑ No

If the answer to ALL of the above questions is NO, then a TB test is NOT NEEDED and no further action is required.

If the answer to ANY of the above questions is YES, then you are required to provide documentation of a TB test, and to have your health care provider complete Part F, *Medical Evaluation for Latent Tuberculosis Infection*. The TB test must be completed within 6 months prior to entrance into ENC, unless you have had a previous positive TB blood test (IGRA). If you have had a positive TB skin test in the past, then you must submit either documentation of treatment for Latent Tuberculosis or results of a TB blood test (IGRA).

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

Afghanistan
Algeria
Angola
Anguilla
Aregentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Rep.
Chad
China
China, Hong Kong SAR
China, Macao SAR
Columbia
Comoros
Congo
Congo, DR
Côte d'Ivoire
Djibouti
Dominican Rep.
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Fiji
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Korea, DPR
Korea, Rep.
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia, FS
Moldova, Rep.
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Swazilan
Syrian Arab Rep.
Tajikistan
Tanzania, UR
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Rep. of)
Vietnam
Yemen
Zambia
Zimbabwe

*World Health Organization. Global tuberculosis control. WHO report 2015

PART F • MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

THIS FORM IS TO BE COMPLETED AND SIGNED BY A LICENSED HEALTHCARE PROVIDER.

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

PLEASE NOTE: If the answer to all questions on Part E is "NO," then a TB Test is NOT NEEDED.

A. TB Test – ONLY REQUIRED if the student answered YES to any one of questions 2-6 on Part E.
If needed, a TB test must be completed within 6 months prior to entrance into ENC.
However, if the student has had a positive IGRA in the past, then go directly to section B below

OPTION 1 (Preferred):

IGRA – INTERFERON GAMMA RELEASE ASSAY

Date obtained ____/____/____ (specify method) ❑ QFT-GIT ❑ T-Spot ❑ Other________________

Result ________________________

OPTION 2:

TUBERCULIN SKIN TEST

Date test administered: ____/____/____ Date test read: ____/____/____ Result _____mm of induration

INTERPRETATION OF TUBERCULIN SKIN TEST: *(Please use table below)* ❑ Negative ❑ Positive

If TB skin test is POSITIVE, then an IGRA test is required.

RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country that has a high rate of tuberculosis	10 mm or more
No risk factors (test not recommended)	15 mm or more

B. If IGRA is POSITIVE, now or by history, the following are required:

1. Date of positive IGRA

   Date: ____/____/____

2. Chest X-ray: Required (Attach report, NOT the X-ray)

   Date: ____/____/____
   ❑ Normal ❑ Abnormal ________________________
   Describe

3. Clinical Evaluation:
   ❑ Normal ❑ Abnormal ________________________
   Describe

4. Treatment
   ❑ Yes ________________________
   Drug, dose, frequency and dates
   ❑ No (Explain) ________________________

HEALTH CARE PROVIDER *(please print)* ________________________ Phone ____________

Address ________________________ FAX ____________

Provider's Signature ________________________ Date: ____/____/____