



Eastern Nazarene College

HEALTH FORM INSTRUCTIONS

All students, commuter and residential, 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: Campus Nurse. 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 in blue or black ink 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 completed, 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 Record*, completed, signed, and dated by a health care provider. You must have appropriate documentation for every required vaccine.

COVID-19 Vaccination Disclosure Required: The COVID-19 vaccine is recommended for all students if medically indicated. Disclosure of vaccine status is required.

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:

It is a Massachusetts state law that all students carry adequate 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 Student Health Insurance Plan by completing the form at universityhealthplans.com. This will need to be completed every academic year that you are a student at ENC. If you neglect to complete the online waiver or enrollment, you will be manually enrolled in and billed for the Student Health Insurance Plan. 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 notified and enrolled in the Student Health Insurance Plan. The cost will remain on your student bill.

DEADLINES:

Fall Semester – July 31

Spring Semester – November 30

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: Campus Nurse, 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 giving you further steps if needed.

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 every few 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 - November 30

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

Preferred Name: _____
Last First MI

Birthplace: _____
Country

Permanent Address: _____
Street

Gender Identity: _____

City State/Country Zip/Postal Code

Preferred Pronouns: _____

Best Phone: (____) _____ Sex assigned at birth: Female Male Other Decline to answer

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 online.
- I am aware that I still need to complete the insurance enrollment or waiver form online.

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

State of Massachusetts

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

OR Lab test proving immunity (attach lab reports)

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

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

OR Lab test proving immunity (attach lab report)

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

Immune – titer value _____ Date: ____/____/____

OR Reliable history of chickenpox disease

If this box is checked, this form MUST 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 ____/____/____ OR DPH Waiver, if not immunized, must be signed and returned with this form.
Waiver can be downloaded at:

<https://enc.edu/wp-content/uploads/2021/07/Meningitis-Waiver-Form-2021.pdf>

RECOMMENDED IMMUNIZATIONS

MENINGITIS B • Optional

Meningitis B Dose #1 Date ____/____/____

Meningitis B Dose #2 Date ____/____/____

INFLUENZA • Recommended

Type _____ Date ____/____/____

COVID-19 • Recommended

Type _____

Dates ____/____/____ ____/____/____

Booster _____

Dates ____/____/____ ____/____/____

HEALTH CARE PROVIDER (please print) _____ Phone _____

Address _____ FAX _____

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

COVID-19 Vaccine Disclosure Required

Eastern Nazarene College is committed to providing a safe and healthy environment for our students and thus generally follows the recommendations of local, state, and federal health departments. ENC's Health Services team **recommends** that every eligible student receive and remain up to date on their COVID-19 vaccination as a primary prevention and disease mitigation strategy.

All new students for Fall 2022 are required to disclose their vaccination status.

Please select one of the following:

- I am up to date with my COVID-19 Vaccine (I have received my primary series and all boosters for which I am eligible, according to the CDC—Centers for Disease Control & Prevention.)
- I am partially vaccinated against COVID-19 (I have received only one shot or I am due for a booster.)
- I am not vaccinated against COVID-19, but I do intend to get vaccinated.
- I do not intend to get vaccinated against COVID-19.

Name (Print Clearly): _____

Signature: _____

Date of Birth: _____

Phone Number: _____

Date: _____

Health information may be faxed to 617-745-3928 or mailed to Eastern Nazarene College Health Services at 23 E. Elm Avenue, Quincy, MA 02170. If you have any questions, please call Health Services at 617-745-3893 or 617-745-3892 or send an email to healthservices@enc.edu.

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

Source: World Health Organization. Global Health Observatory, TB Incidence 2018 and World Health Organization. Tuberculosis Report, 2021

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: ____/____/____