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/guardian 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 all questions**.

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 of the date that you enter Eastern Nazarene College. If you are an athlete**, the NCAA requires that you have a physical exam **within six months, as well as documentation of Sickle Cell Trait testing**. 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.

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** and should be filled out by a licensed healath care provider.

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. We strongly recommend that you begin the enrollment or waiver process early, if possible, so you have time to research your options and make a decision prior to coming to campus and before the start of the sememster.

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 receive 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 strongly recommend making a copy of the Student Health Form for your personal 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 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

HEALTH 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, and Part F, if required. We strongly recommend 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 Life, Counseling Services 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 (**Required 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

Documentation of Immunizations

Print Last Name: _____ Print First Name:_____ Date of Birth: _____/_____/_____
Month Day Year

REQUIRED IMMUNIZATIONS

The Commonwealth of Massachusetts and ENC require all students (residential and commuter) to be immunized against certain communicable diseases. All dates must include month, day and year. To comply, have this form completed and signed by your healthcare provider unless there is a copy of an immunization record. Once completed by the provider, the student must submit all documents to ENC Health Services as soon as possible and no later than July 31 (Fall enrollment) and November 30 (Spring enrollment). **If providing serologic proof of immunity, you must include laboratory test results when submitting this form.**

REQUIRED VACCINES	DATES GIVEN	MA STATE REQUIREMENTS
MMR (Measles, Mumps, Rubella) Series of 2 immunizatoins OR Laboratory evidence of immunity is acceptable in lieu of immunization	MMR: #1 _____/_____/_____ #2 _____/_____/_____ OR **Measles** ❑ Immune – Titer Value _____ Date ___/____/____ **Mumps** ❑ Immune – Titer Value _____ Date ___/____/____ **Rubella** ❑ Immune – Titer Value _____ Date ___/____/____	Dose #1 must be given on or after the 1st birthday Dose #2 must be given ≥ 28 days after the first dose OR laboratory evidence of immunity is acceptable
Tdap (Tetanus-Diphtheria-Pertussis)	Tdap Vaccine Date _____/_____/_____ *If ≥ 10 years ago, you must also provide date of current Td or Tdap _____/_____/_____	Tdap must be given on or after age 7. *NOTE: If Tdap was given ≥10 years ago, you must also provide a current Td or Tdap vaccine.
Hepatitis B Series of 3 immunizations OR 2 immunizations of Heplisav-B* OR Laboratory evidence for immunity is acceptable in lieu of immunization	**Vaccine name** _____ #1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____ OR ❑ Immune – Titer Value _____ Titer Date _____/_____/_____	Dose #1: May be given at any age. Dose #2: at least 4 weeks (28 days) after dose #1. Dose #3: given at least 8 weeks (56 days) between #2 and #3. There must be at least 16 weeks (112 days) between #1 and #3. *NOTE: 2 doses of Hepisav-B must be given on or after 18 years of age and at least 4 weeks apart OR proof of serolgic immmunity is acceptable*.
Varicella – Chickenpox Series of 2 immunizations OR Laboratory evidence for immunity is acceptable in lieu of immunization OR Reliable history of Chickenpox	#1 _____/_____/_____ #2 _____/_____/_____ OR ❑ Immune – Titer Value _____ Titer Date ___/____/____ OR ❑ Reliable history of Chickenpox Disease*	Dose #1must be given on or after 1st. birthday. Dose #2 must be given at least 28 days after dose #1 OR Proof of serologic immunity is acceptable*. *NOTE: A reliable history of chickenpox disease MUST BE SIGNED below by an MD, PA, or NP.
Meningococcal Quadrivalent Required for students 21 years of age or younger; vaccine must be given on or after 16th birthday	MenACWY Vaccine Date _____/_____/_____ Check which vaccine was administered: ❑ Menactra ❑ Menveo ❑ Other _____ OR ❑ Signed Waiver Form*	Meningococcal Information and Waiver Form *Please sign after reading the MDHP Meningococcal Information form.
STRONGLY RECOMMENDED / ADDITIONAL IMMUNIZATIONS AND STANDARD DOSING		
COVID-19 Date of most recent dose	Date _____/_____/_____	Accepted Vaccines: Pfizer-BioNTech; Moderna; WHO EUL Vaccine
Influenza Date of most recent dose	Date _____/_____/_____	The CDC recommends that everyone 6 months and older in the United States should get a flu vaccine every season with rare exceptions.
Meningococcal Group B MenB-4C (Bexsero)	#1 _____/_____/_____ #2 _____/_____/_____	2 doses - Second dose at least 1 month after the first dose
Meningococcal Group B MenB-FHbp (Trumenba)	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____	2 or 3 doses - For those not at risk, 2 doses, second dose 6 months after the first dose. Those at increased risk 3 doses. Second dose 1-2 months after first dose. Third dose 6 months after the first
HPV (Human Papillomavirus)	#1 _____/_____/_____ #2 _____/_____/_____ #3 _____/_____/_____	3 doses over 6 months. Reommended for everyone through age 26

Licensed Medical Provider Verification (MD, DO, PA, NP, RN) • REQUIRED

Provider's Printed Name_____ Date _____/_____/_____

Address (Including City and Sate) _____ Phone _____

Provider's Signature/Credentials _____ FAX _____

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
Algeria
Angola
Anguilla
Argentina
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
Colombia
Comoros
Congo
Congo, DR
Côte d'Ivoire
Djibouti
Dominica
Dominican Rep.
Ecuador
EI Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao PDR
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia, FS
Moldova, Rep.
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
North Korea, DPR
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Korea (Rep. of)
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Tanzania, UR
Thailand
Timor-Leste
Togo
Tokelau
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Rep. of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: World Health Organization. Global Health Observatory, TB Incidence 2020 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 HEALTH CARE 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: ____/____/____