**WELLESLEY COLLEGE MEDICAL FORM**

***Completed form must be uploaded through the Patient Gateway by July 3, 2024***

* **Submissions MUST INCLUDE a legible copy of your COMPLETE IMMUNIZATION RECORD**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (MM/DD/YY) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*To be completed and signed by a health care provider:*

**Physical Exam**: Date: \_\_\_\_\_\_\_\_\_

Ht\_\_\_\_\_\_ Wt \_\_\_\_\_\_\_ BMI \_\_\_\_\_ BP: \_\_\_\_\_\_\_\_ HR:\_\_\_\_\_\_

Please describe any abnormalities on physical exam:

**Family History** (include medical & mental health diagnoses):

□ NONE □ UNKNOWN/ADOPTED

|  |  |
| --- | --- |
| Father |  |
| Mother |  |
| Siblings |  |

**Allergies (include reaction):** □ NONE

**Past/current mental health diagnoses and hospitalizations** □ NONE

Mental health specialists (contact information/reason for seeing):

**Past/current medical diagnoses and hospitalizations** □ NONE

Medical specialists (contact information/reason for seeing):

**Medications (Name/Dose):** □ NONE

|  |  |
| --- | --- |
| **TB Screening Questions** |  |
| Have you ever had a positive TB skin test? | □ Yes □ No |
| Have you had close contact with anyone known or suspected of active TB? | □ Yes □ No |
| In what country were you born? |  |
| Were you born in a high TB risk country? (see list under Supplemental Information) | □ Yes □ No |
| Within the past 5 years, have you lived in or traveled to a high-risk country for >1 month? | □ Yes □ No |
| Have you worked/lived in a high-risk congregate care setting (jail, homeless shelter, substance/long term care facility)? | □ Yes □ No |

If the answer to all of the questions is NO, no further testing is required.

**If the answer to ANY question is YES:**

* You must have an IGRA blood test (preferred) or a TST/PPD within 3 months of matriculation and upload results with your forms
* You must also submit the **Supplemental TB Screening Form** (available at www.wellesley.edu/healthservices)

**HEALTH CARE PROVIDER** (may NOT be a family member)*:*

*I have reviewed the patient’s history/immunizations and examined this patient, and the information is accurate and complete to the best of my knowledge. The patient is physically and mentally fit to attend college and participate in all activities.*

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do not forget to submit **a legible copy of your COMPLETE IMMUNIZATION RECORD**

Health Services Provided by Newton Wellesley Medical Group | [www1.wellesley.edu/healthservice/incomingstudents](mailto:www1.wellesley.edu/healthservice/incomingstudents) | 727 Washington St Wellesley, MA 02481 | Office: 781.283.2810 | Fax : 617.831.7234 | Gateway : https://patientgateway.massgeneralbrigham.org