SMITH COLLEGE

Schacht Center for Health and Wellness and Pelham Medical Services
21 Belmont Avenue, Northampton Massachusetts 01063
Phone 413-585-2800 Fax 413-585-4639
smith.edu/health

School for Social Work Deadline:
April 10th: All programs and sessions

HEALTH FORM PACKET: REQUIRED OF ALL STUDENTS

- **All pages must be completed with name, date of birth and Smith ID number, and signed as indicated.**
- **All students must submit proof of required immunizations and tuberculosis screening.**
- **Refer to our website for additional forms, FAQs, and tips to find past records and low-cost clinics.**
- **Your primary care provider, most U.S. retail pharmacies, or walk in/urgent care clinics are able to provide tuberculosis testing, and administer vaccines.**

Important notes:

- **Health Holds will be placed on student accounts until all requirements are met.**
- You must provide proof of all required information by your program deadline and prior to registration and orientation.
- If you are unable to complete all doses in a series of vaccine (i.e. Hepatitis B, MMR, Varicella) by this time, you must submit proof of at least one dose per series. We will adjust the dates of your health holds as needed to minimize inconvenience. Students are not able to register for classes and/or progress to field placement until complete documentation has been provided and your health file is cleared. Federal loans may be impacted if your account is on hold.

☐ **Page 1: Student information and Emergency Contact Information.**

☐ **Page 2: Immunizations: Submit proof of required immunizations OR immunity by blood test.**
- Upload the enclosed form, completed and signed by your physician OR a copy of your immunization record.
- Questions about Vaccine Waivers should be directed to healthservices@smith.edu.
- Current requirements are:
  - COVID-19 vaccine: WHO approved. Boosters are required per CDC recommendations.
  - MMR vaccine: 2 doses OR copy of a blood test showing immunity.
  - Hepatitis B vaccine: 3 doses OR copy of a blood test showing immunity.
  - Varicella vaccine: 2 doses OR copy of a blood test showing immunity OR physician verified disease.
  - Tdap (Adacel or Boostrix) vaccine: one dose TD or TDAP in past ten years. (Provide record of childhood series, if it is available).
  - Meningitis MenACWY/MCV4 vaccine: 1 dose since age 16 (ONLY for students 21 years of age or younger).

☐ **Page 3: Tuberculosis Risk Screening: Date of screening/testing must be *within 3 months prior to matriculation*.**
- Tuberculosis screening questionnaire must be completed and signed by student AND provider.
- Testing is needed ONLY if you answer YES to any of the items on the screening questionnaire.
- Submit copies of written blood test report(s) and/or chest x-ray report(s).

► UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL (https://smith.medicatconnect.com)
- Online instructions and additional forms are at smith.edu/health.
- You may mail or fax records if needed.
- *Do not email forms, health records or test results. They will not be accepted.*

QUESTIONS? Please contact healthservices@smith.edu or call 413-585-2800.

UPLOAD all information.
We do not accept emailed information due to confidentiality concerns.
Keep a copy of all information sent.

SMITH COLLEGE

This page must be completed by all students.

Last Name____________________ **First Name**____________________ **Date of Birth** ___/___/____ **Smith ID# 99** ____________

MM DD YYYY

STUDENT INFORMATION

Chosen Name __________ Chosen Pronouns __________ Assigned Sex at Birth __________

Street Address __________

City/State/Region/Country/Zip Code __________

Telephone __________ Email __________

Country of Birth __________ ☐ Undergraduate ☐ Ada ☐ Graduate ☐ Transfer Class of: __________

EMERGENCY CONTACT

Name of individual(s) over age 18 to be contacted in an emergency and who is able to make medical treatment decisions. *If the student is younger than age 18, the legally responsible parent(s) or guardian must be listed first. Please include a U.S. contact.*

Name __________ Relationship to Student __________

Telephone 1 __________ Telephone 2 __________ Email __________

Name __________ Relationship to Student __________

Telephone 1 __________ Telephone 2 __________ Email __________

This page is to be completed by student/family. Upload this completed page to the patient portal at smith.edu/health.
Do not give this page to your doctor.

SMITH COLLEGE

This page must be completed by all students.
Physician signature required.

Last Name____________________ **First Name**____________________ **Date of Birth** ___/___/____ (MM DD YYYY) **Smith ID# 99** ____________

IMMUNIZATIONS

- **ALL students must comply with Massachusetts School Immunization Requirements.**
- **Submit a copy of your immunization records OR this form, signed by your health care provider.**
- **If titer blood tests were performed, a copy of the blood test result is required.**

Failure to meet all requirements by the deadline will result in a hold on all student accounts.

Most U.S. retail pharmacies and walk-in or urgent care clinics can provide and administer vaccines.

REQUIRED IMMUNIZATIONS: Include dates of administration in MM/DD/YYYY format	Date Dose 1 MM/DD/YYYY	Date Dose 2 MM/DD/YYYY	Date Dose 3 MM/DD/YYYY	Date Dose 4 MM/DD/YYYY	TITER: Date and Result *Include copy of results if titers are performed*
COVID-19 ☐ Johnson & Johnson (Janssen) ☐ Moderna ☐ Pfizer ☐ Other: Boosters are required per CDC guidelines. Bivalent booster required. (Must be WHO approved)			(booster)	(booster)	N/A
Tetanus-Diphtheria-Pertussis Completed childhood primary series (date of **final dose** of DTP/DTaP)					N/A
Tdap (Adacel or Boostrix) 1 dose within 10 years					N/A
Hepatitis B (Specify if Heplisav-B) 3 doses (0, 1 month, 4–6 months apart) **or** positive titer (lab report required)					
MMR: Measles, Mumps, Rubella **MMRV: Measles, Mumps, Rubella, Varicella** 2 doses of MMR or MMRV 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titers for each (lab report required)					
Varicella (Chicken Pox) 2 doses 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titer (lab report required) or *provider-verified medical documentation of disease with date*					
Quadrivalent Meningitis (Students age 21 or younger) (MenACWY/MCV4/Menactra/Menveo) 1 dose *on or after age 16*					N/A

I HAVE REVIEWED THIS HISTORY WITH THE STUDENT AND ATTEST TO ITS ACCURACY.

Provider Name **M.D./ D.O. N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Upload this completed page to the patient portal at smith.edu/health.
Your health care provider's office may fax this form, test results and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

This page must be completed by all students.
Physician signature required.

Last Name__________________ **First Name**__________________ **Date of Birth** ___/___/_____ **Smith ID# 99** ___________
MM DD YYYY

TUBERCULOSIS (TB) RISK SCREENING (Required for ALL Students) **Complete within 3 months prior to matriculation.**

If the answer to any question below is ***YES****, additional testing is required prior to arrival on campus.*

			Date(s)
1. Have you ever had a positive tuberculosis (TB) skin test?	☐ Yes	☐ No	___________
2. Have you ever had close contact with anyone who was sick with TB?	☐ Yes	☐ No	___________
3. Were you born in one of the countries listed below?	☐ Yes	☐ No	___________
4. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks?	☐ Yes	☐ No	___________

5. Please CIRCLE the country in which you were born, AND any of the countries you lived in within the past five years, or traveled to for more than two weeks.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El 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 People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

Source: https://www.acha.org/documents/resources/guidelines/ACHA_Tuberculosis_Screening_Feb2021.pdf

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

If the answer to ANY of the questions above is YES:

Does the student have a past or current diagnosis of, or any symptoms of active tuberculosis? ☐ **Yes** ☐ **No**
If YES: Provide documentation of treatment dates, medications taken, sputum results, and chest x-ray reports.

Blood Test is Required if any question above is marked YES.
Perform an Interferon Gamma Release Assay (IGRA): TSPOT or Quantiferon Gold AND attach copy of test results.
Date of blood test: ______________ **Result:** Negative _____ Positive ____ Indeterminate ______

☐ **Submit copy of test results**
If IGRA is negative, no further action is required.
TB IGRA testing MUST be completed prior to arrival on campus.

Chest x-ray required if blood test is positive OR indeterminate OR not available.
Provide full narrative copies of blood test reports AND chest x-ray reports, preferably in English.

ABNORMAL RESULTS require immediate medical evaluation. Please contact your PCP promptly for next steps and notify the Schacht Center with any abnormal results.

Chest X-ray: ***Required if IGRA is positive OR if skin test is positive. Must be dated 3 months prior to matriculation.***

☐ Date of chest X-ray ___ /___ /______ **Result:** Normal ____ Abnormal _____
MM DD YYYY

☐ Attach chest X-ray report ☐ Attach consultation note

Student/Legal Guardian Signature: **Date**

I HAVE REVIEWED THIS FORM AND ATTEST THAT THE STUDENT IS AT LOW TO NO RISK FOR TUBERCULOSIS EXCEPT AS INDICATED ABOVE.

Provider Name **M.D./ D.O./N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Upload this completed page to the patient portal at smith.edu/health.
Your health care provider's office may fax this form, test results and a copy of your immunization records to 413-585-4639.