Name _____ Curry College ID @_____

Curry College Health Services
1071 Blue Hill Avenue
Milton, MA 02186
617-333-2182 (phone)
617-333-2029 (fax)
healthservices@curry.edu

Dear Student and Parent:

- **ALL** newly enrolled full-time undergraduate students need to complete this form.

- The Health Form must be submitted directly to Health Services via mail, fax (617-333-2029) or email, healthservices@curry.edu. **Please keep a copy for your records.**

- Please fill out demographic information on page one, health insurance information on page two, and the TB Questionnaire on page three. All health information on page two and your immunization history on page three should be completed and signed by a healthcare provider. The TB questionnaire is to be completed by you and reviewed by your healthcare provider.

- Please note, a physical exam is NOT required by the college. If you are an **NCAA athlete**, additional requirements and forms can be found on the Athletics website under Sports Medicine.

- All **Nursing and Exploratory Health students** are required to have a reactive Hepatitis B titer regardless of vaccination history in order to begin clinical placement work your second year. If your titer is non-reactive, you will require further immunization. Proof of immunity to varicella is required either by a reactive varicella titer OR two immunizations. If you require additional information please contact the School of Nursing at 617-391-5214.

- Once the form is reviewed by Health Services the hold will be removed from the Student Portal. If the form is incomplete, you will be notified by phone or email and a health clinic hold will remain on the student's portal .

- **Massachusetts State law requires students enrolled in 75% of full-time curriculum in any Massachusetts institution of higher education to participate in a school-sponsored qualifying student health insurance program or an alternate health plan with comparable coverage.** *Travel medical insurance plans and international insurance plans will NOT be accepted for the 2020-2021 academic year.* Out-of-state Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs) and Out of State Medicaid Programs generally have a limited network of providers that will not provide comprehensive coverage in the area surrounding Curry College. Kaiser and Anthem are popular out of state HMO plans that do not provide coverage, other than for emergency situations, in Massachusetts. If you need lab work, imaging or a referral to a specialist, services may not be covered by your insurance. Therefore, before you waive the Curry College Student Health Plan, please make sure your current insurance coverage is comparable to the Student Health Insurance Plan. For additional information please visit: www.curry.edu/healthservices.

- If you have any questions or concerns, please call us at 617-333-2182 or email healthservices@curry.edu .

Thank you,
Health Services

Name _____ Curry College ID @_____

Curry College Health Form

Student Information

Last Name **First Name** **Middle Initial**

Date of Birth **Country of Birth** **Gender** **Major**

Home Address

City **State** **Zip Code** **Country**

Home Phone Number **Cell Phone Number** **Email**

Parent/Next of Kin/Emergency Contact

Name **Relationship**

Address Street **City** **State** **Zip** **Country**

Home Phone **Work Phone** **Cell Phone**

Email

Alternate Emergency Contact

Name **Relationship**

Address Street **City** **State** **Zip** **Country**

Home Phone **Work Phone** **Cell Phone**

Return completed form to:
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Milton, MA 02186
Fax: 617-333-2029
healthservices@curry.edu

DEADLINES:

July 31, 2020

January 4, 2021

IMPORTANT NOTE:

The Health Form is a separate requirement from documentation of student health insurance coverage.

To enroll or waive the College's health insurance coverage, please visit

www.curry.edu/healthservices

CONSENT FOR MEDICAL CARE FOR STUDENTS UNDER 18

SIGNATURE OF PARENT/GUARDIAN REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE, AND IS VALID UNTIL AGE 18 I HEREBY GRANT PERMISSION TO THE DIRECTOR OF CURRY COLLEGE HEALTH SERVICES OR AUTHORIZED REPRESENTATIVES, TO PROVIDE SUCH MEDICAL CARE AS MY CHILD, _____, MAY REQUIRE WHILE AT CURRY COLLEGE, INCLUDING EXAMINATIONS, DIAGNOSTIC TESTING, TREATMENT OR IMMUNIZATIONS. THIS ALSO INCLUDES REFERRAL TO AN OUTSIDE PROVIDER, LOCAL HOSPITAL, HOSPITALIZATION, ANESTHESIA AND /OR SURGERY SHOULD IT BE NECESSARY IN THE EVENT OF SERIOUS ILLNESS OR INJURY AND I AM UNABLE TO BE REACHED.

Name of Parent/Guardian.....Signature.....Date.....

Printed Name of Parent/
Guardian.....Signature.....Dare.....

PLEASE FEEL FREE TO CONTACT HEALTH SERVICES, 617-333-2182, WITH QUESTIONS OR CONCERNS

Name _____ Curry College ID @_____

Medical History

Please list all current medications including dosage

……

Please list and describe all allergies (medication, food, environmental)

……

Please list current medical problems

……

Please list all hospitalization (including medical, surgical and psychiatric admissions)

……

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Medical Provider Information (Primary Care Doctor)

……
Medical Provider Signature Date

……
Medical Provider's Name (please print)

……
Address

……
City State Zip Code

……
Phone Number Fax Number

NOTE:

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Health Insurance Information

Curry College Health Insurance ☐

Insurance Provider……

Policy Number……Group Number……

Guarantor……Guarantor's Date of Birth……

Relationship to Guarantor……

ATTACH COPY OF FRONT AND BACK OF HEALTH INSURANCE CARD

PLEASE FEEL FREE TO CONTACT HEALTH SERVICES, 617-333-2182, WITH QUESTIONS OR CONCERNS

Name _____ Curry College ID @_____

Tuberculosis (TB) Risk Questionnaire

Have you ever had a positive TB skin test? ☐Yes ☐No

Have you had close contact to someone sick with infectious TB? ☐Yes ☐No

Were you born or lived in a country with a high rate of TB including any country in Asia, Africa, Central America, South America, Mexico, Eastern Europe, Caribbean, or the Middle East? ☐Yes ☐No

Are you immunosuppressed? (Persons with HIV infection; organ transplant recipient; treated with TNF-alpha antagonist; long-term steroid use or other immunosuppressive medication). ☐Yes ☐No

If the answer is YES to any of the above questions, you are considered high risk and Health Services requires a Tuberculosis Skin Test or Interferon-Gamma Release Assay (IGRA), and results documented below. If you were foreign born and have a history of BCG vaccination, IGRA testing is preferred. If you have a history of positive skin test or IGRA, repeat testing is NOT required but chest x-ray results and treatment dates must be listed below:

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

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Interferon-Gamma Release Assay (IGRA) Date: Result:	PPD Date Given Negative Date Read Positive	PPD +, Chest X-Ray Result Negative Positive	PPD+ with x-ray negative Prophylactic Medication	Length of Tx Date Completed

Immunization Requirements For All Students

Required by Massachusetts Department of Public Health

You may attach separate proof of immunization from your physician

Hepatitis B	Date of Dose #1	Date of Dose #2	Date of Dose #3	**OR** Titer Date Result	
Measles, Mumps, Rubella, (MMR) Dose 1 on or after 1st birthday	Date of Dose #1	Date of Dose #2	**OR** Measles Titer Result	Mumps Titer Result	Rubella Titer Result
Meningitis (MenACWY) On or after 16th birthday for students under age 21	Date of Dose	Signed Waiver Form (see attached)	**Meningococcal Serogroup B (MenB)** *Recommended but not required*	Date:	
Tdap (Tetanus, Diptheria, and Acellular Pertusis)	Date				
Varicella Dose 1 on or after 1st birthday	Date of Dose #1	Date of Dose #2	**OR** Titer Date Result	**OR** Date of Disease	

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