April 16, 2012

Dear Incoming Students and Parents,

Welcome to Bowdoin College! Enclosed in this packet are your health history and physical examination forms and directions for completion and submission.

Completing the paperwork will help the clinical staff to meet your health care needs as you transition from home to college life. Students should fill out the first two pages. Your health care provider must fill out the Physical and Immunization Record. Please check that the health and immunization forms are filled out completely and signed by the provider. If you need additional copies please visit our website at http://www.bowdoin.edu/health/index.shtml. These forms need to be returned to Bowdoin College Health Services no later than July 16, 2012 in the enclosed self-addressed envelope.

Students planning to participate in a varsity sport at Bowdoin MUST have a physical dated within six months prior to the start of classes at Bowdoin, which is August 30, 2012. All other physicals MUST be dated after January 1, 2012.

If you are currently taking prescription medication and you would like the Health Center to assume care for any chronic medical condition requiring routine prescriptions please be prepared to provide appropriate records to verify diagnosis and medications, including medication doses and instructions on administration. If you will need a new prescription for stimulant medications for conditions such as Attention Deficit Disorder, we will ask you to see one of the college’s consulting psychiatrists. They have regular office hours on campus, and may be contacted by calling the Counseling Center. The consulting psychiatrist will be writing all new prescriptions for controlled, psychoactive medications.

We make every effort to work collaboratively with you, your providers at home, and any consultative service you now use or may need while at Bowdoin College.

The staff at Bowdoin College Health Services is here to promote and protect your health and well being. We look forward to meeting you in August and hope that you will have a healthy and productive college experience.

Warmest Regards,

Sandra Hayes, MSN, NP-C

Health Services

3600 College Station • Brunswick • Maine 04011-8427 • Tel 207.725.3770 • Fax 207.725.3905
Check list

Please use this checklist to help ensure that all forms are completed correctly to avoid delaying your registration.

These forms need to be returned to the Bowdoin College Health Services no later than **July 16, 2012** in the enclosed self-addressed stamped envelope.

___ Review the Student Health History form and complete (pages 1 and 2) before you go for your physical appointment.

___ Consent for Treatment of Minors (page 1) has been signed if student is under 18 years of age.

___ Physical (page 3), including Cardiac Screen, completed and signed by your provider.

___ Provider has completed and documented all required vaccinations (page 4):

   ___ M.M.R. (Measles, Mumps, and Rubella) Two doses required – STATE LAW

   ___ Tetanus/Diphtheria (Primary series with DtaP or DTP and Td or Tdap booster within the last ten years – STATE LAW

   ___ Polio (primary series in childhood)

   ___ Varicella (either a history of chickenpox, a positive Varicella antibody titer, or two doses of vaccine given at least one month apart)

   ___ Hepatitis B (three doses of vaccine or a positive Hepatitis B surface antibody titer)

___ Provider has completed and documented **recommended** vaccination: *Meningococcal* vaccine

___ Tuberculin (Mantoux) test with documented results given within 6 months preceding your arrival at Bowdoin IF you are high-risk for TB exposure. High-risk exposure includes: prior close contact with a person with TB; being born in Asia, Africa, Latin America, Eastern Europe or Russia; having traveled to any of these regions in the last five years; having lived or worked in a nursing home, prison, mental institution, homeless or HIV shelter; or history of injection drug use, HIV infection, diabetes, chronic renal failure, immunodeficiency, or immunosuppressive medication.

If your Mantoux skin test is greater than 10mm, you MUST have a chest X-ray. The chest X-ray report must accompany your physical form.

A history of BCG vaccination does not eliminate the requirement. If your reaction to the Mantoux test is greater than 10mm the Maine State Office of TB Control considers that to be an indication of past exposure or possible current infection, not a “BCG Reaction”.

Please make a copy of the Student Health History form for your records.
**Medical Evaluation**

Health Services  
Buck Center for Health & Fitness  
Bowdoin College  
3600 College Station, Brunswick, ME 04011  
Telephone 207-725-3770  
Fax 207-725-3905

**PLEASE NOTE**  
Completed health forms are due by **July 16, 2012**.  
Failure to meet immunization and medical requirements will result in a registration hold.

**For Bowdoin staff use only:**  
Date Received:  
Completed: ☐

**Allergies:**

- MMR #1 ☐ #2 ☐ Titer ☐
- Td ☐ Tdap ☐ Var: disease ☐ vac ☐ 1 or 2 ☐
- HepB #1 ☐ #2 ☐ #3 ☐ Titer ☐
- Meningococcal ☐ MA or ☐ ME ☐
- PPD: N/A ☐ Neg ☐ Pos ☐
- CXR ☐ INH ☐

Athletic Clearance: Yes ☐ No ☐

**Teaching Fellow?** ☐ Yes ☐ No

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**Parent/Guardian Information**

<table>
<thead>
<tr>
<th>(Print) Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of Birth</th>
<th>Citizenship</th>
</tr>
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</table>

<table>
<thead>
<tr>
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<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
<th>Country</th>
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<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Student’s Cell Phone</th>
<th>Ok to leave phone message?</th>
<th>Ok to leave school email message?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Yes ☐ No ☐</td>
<td>Yes ☐ No ☐</td>
</tr>
</tbody>
</table>

**Parent/Guardian Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip code</th>
<th>Country</th>
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</table>

<table>
<thead>
<tr>
<th>Home Phone</th>
<th>Business Phone</th>
<th>Cell Phone</th>
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</tbody>
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**Consent for Treatment of Minors**

Maine law requires that parental permission be obtained for medical treatment of minors except where certain exceptions apply. The law defines “minor” as a person under the age of 18 years.

**Student Name** ___________________________ **Date of Birth** ___________________________

Parent/Guardian Consent:

I hereby authorize Bowdoin College or its authorized representatives to provide such physical and/or mental health treatment, as required, for the student named above. Such care shall include but not be limited to diagnostic examinations (including radiological and laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary medical treatment, and mental health counseling. For surgical procedures or more extensive medical care, reasonable attempts will be made to contact me before such care is initiated. Failure to do so should not prevent Bowdoin College or its authorized representatives from providing such emergency treatment as may be necessary for the best interests of the student.

I understand that the student’s contact with individuals providing physical and mental health services at Bowdoin College are held in confidence, but that such confidentiality may be breached in certain circumstances. Including but not limited to the event that the student’s safety or that of another person is in imminent danger, in accordance with state and federal laws and regulations.

I further understand and agree that this authorization will be in effect until the student reaches the age of 18 years. By signing this authorization form, I acknowledge that I have read and understand this consent.

Signature of Parent/Guardian ___________________________  
Printed Name of Parent/Guardian ___________________________  
Date ___________
Bowdoin College
MEDICAL HISTORY
(To be completed by student)

FAMILY HISTORY:  Mother’s age ___________________ Occupation ___________________ Health Status ___________________

Father’s age ___________________ Occupation ___________________ Health Status ___________________

Brother/Sister’s age(s) ___________________ Health Status ___________________

Any family history of blood disease, seizures, cancer, diabetes, psychiatric illness, heart or kidney disease, asthma, alcohol or drug abuse? ___

Have any of your grandparents, aunts or uncles died? If so, age and what from? ___

PERSONAL HISTORY:  Do you have or have you ever had: (check all that apply)

- Anemia
- Appendectomy
- Arthritis
- Asthma
- Cancer
- Concussion/head injury
- Crohn’s/ulcerative colitis
- Chicken pox
- Depression
- Diabetes
- Disordered eating
- Heart disease/problem
- Hepatitis
- High blood pressure
- High cholesterol
- Impaired vision/blindness
- Impaired mobility
- Irritable Bowel Syndrome
- Kidney disease/stones
- Learning disability
- Loss of paired organ
- Migraines
- Mononucleosis
- Neurological disease
- Phlebitis/deep vein clot
- Sickle cell disease or trait
- Thyroid disease
- Positive TB test
- Other psychiatric illness
- UTI’s (freq/recurrent)

HOSPITALIZATIONS: Please list all medical, surgical and psychiatric hospitalizations with dates and diagnosis:  □ None

MEDICATIONS: Please list all prescribed and over the counter medications including birth control, asthma medications, antidepressants, supplements and herbs:

ALLERGIES: □ None known  □ Yes

If yes, please specify (including medications, insects, foods, environmental):

Describe type of reaction: ___________________________ Do you have an EpiPen? □ Yes □ No

MENSTRUAL HISTORY: Have you ever had a period? ___ Yes ___ No  Age of first period? _______ Number of periods in the past year? _______

LIFESTYLE: Do you exercise? □ Never  □ Occasionally  □ 3-5 times a week  □ Daily  Type of exercise ___________________________

Has your physical activity been restricted in the past 5 years? □ No  □ Yes  If yes, please explain ___________________________

Do you cough, wheeze or have difficulty breathing during or after exercise? □ No  □ Yes

Do you wear a seat belt? ___ No ___ Yes  Do you wear a helmet when you skateboard, bicycle, motorcycle, snowmobile or use an ATV? ___ No ___ Yes

Do you smoke or chew tobacco? □ Never  □ Socially (describe pattern ___________________________ ) □ Daily (how much? _____________)

Do you use recreational drugs? □ No  □ Yes  If yes, which ones? ___________________________

Do you drink alcohol? □ No  □ Yes  If yes, how often? ___________________________ When you drink, how many do you have? ___________________________

Have you been ill, injured or not recalled events after using drugs or alcohol? ___ No ___ Yes

Do you have concerns about your weight? □ No  □ Yes  Do you often feel anxious, overwhelmed or depressed? □ No  □ Yes
**Bowdoin College**  
**PHYSICAL EXAM**

*To be completed by provider no earlier than January 1, 2012  
Please answer all questions and provide all physical data requested on the form*

**Student:**  
**Date of Birth:**  
**Date of exam:**

**ALLERGIES** (medicines, pollens, foods or stinging insects):  
Type of Reaction:  

**CURRENT MEDICATIONS** (Include vitamins, herbs, contraceptives):  

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1. Students planning to participate in intercollegiate sports: *NCAA rules mandate* a physical within 6 months prior to the first day of classes, August 30, 2012.
2. Students weighing 10% less than ideal body weight will be asked to see a provider at the college health center within one week of arriving on campus.

<table>
<thead>
<tr>
<th>Cardiac Screening</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior exertional chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior exertional syncope/near syncope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excessive, unexplained shortness of breath or fatigue with exercise</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior history of heart murmur, heart infection or increased blood pressure</td>
<td></td>
<td></td>
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<tr>
<td>Family history of premature death from cardiovascular disease in a relative younger than age 50</td>
<td></td>
<td></td>
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<tr>
<td>Family history of hypertrophic or dilated cardiomyopathy, long QT syndrome or Marfan’s syndrome</td>
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<td></td>
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<tr>
<td>Prior head injury or concussion</td>
<td></td>
<td></td>
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<tr>
<td>Restricted eating, binging, purging or diagnosed eating disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Height**  
**Weight**  
**BMI (required)**  
**BP**  
**Vision:**  
Corrected R 20/  
L 20/  
Uncorrected R 20/  
L 20/

**LMP**  
**Hgb/Hct**

<table>
<thead>
<tr>
<th>System</th>
<th>Check if Normal</th>
<th>Describe abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymph Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breasts</td>
<td></td>
<td></td>
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<tr>
<td>Back</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rectal (if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Status of Current Medical Problems** (If the student is under care for a chronic condition or serious illness, please include additional records to assist us in providing continuity of care):  

Does Student Require Follow-Up?  
☐ Yes  
☐ No

**Recommendations for Physical Activity** (intercollegiate, intramural, club, recreational):  
☐ Unlimited  
☐ Limited

**Health Care Provider Signature**  
**Printed Name**  
**Date**

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Mail form by July 16, 2012 to:  
Health Services, Buck Center for Fitness & Health  
Bowdoin College, 3600 College Station  
Brunswick, ME 04011
### Bowdoin College
### IMMUNIZATION RECORD

**Name:**

**Date of Birth:**

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**PLEASE NOTE:** Return by July 16, 2012
Health Services
The Buck Center for Health & Fitness
3600 College Station, Bowdoin College
Brunswick, ME 04011

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![Image of form]

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This form must be completed and signed by a health care provider. **You may not register for classes until complete immunization information is received.** Attached documents in a language other than English must be translated into English by the health care provider.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Guidelines</th>
<th>Dates Administered</th>
<th>1/1</th>
<th>2/1</th>
<th>3/1</th>
<th>4/1</th>
<th>Last Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR (combined vaccine: measles, mumps, rubella)</td>
<td>2 doses required after 1st birthday and a minimum of 28 days apart</td>
<td>1/1</td>
<td>2/1</td>
<td>OR documentation of one of the following:</td>
<td>Titer</td>
<td>Date of Disease</td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>2 doses required if no MMR</td>
<td>1/1</td>
<td>2/1</td>
<td>OR documentation of one of the following:</td>
<td>Titer</td>
<td>Date of Disease</td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>2 doses required if no MMR</td>
<td>1/1</td>
<td>2/1</td>
<td>OR documentation of one of the following:</td>
<td>Titer</td>
<td>Date of Disease</td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>2 doses required if no MMR</td>
<td>1/1</td>
<td>2/1</td>
<td>OR documentation of one of the following:</td>
<td>Titer</td>
<td>Date of Disease</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Guidelines</th>
<th>Dates Administered</th>
<th>1/1</th>
<th>2/1</th>
<th>3/1</th>
<th>4/1</th>
<th>Last Booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus-Diphtheria</td>
<td>Primary series with booster in the last 10 years required</td>
<td>1/1</td>
<td>2/1</td>
<td>3/1</td>
<td>Td or Tdap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio</td>
<td>Primary series required</td>
<td>1/1</td>
<td>2/1</td>
<td>3/1</td>
<td>Booster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>Two doses recommended if no disease</td>
<td>1/1</td>
<td>2/1</td>
<td>OR documentation of one of the following:</td>
<td>Titer</td>
<td>Chicken Pox Date of illness:</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Required</td>
<td>1/1</td>
<td>2/1</td>
<td>3/1</td>
<td>OR documentation of</td>
<td>Hep B surface antibody:</td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>Recommended</td>
<td>1/1</td>
<td>2/1</td>
<td>Please circle type:</td>
<td>Menomune Menactra</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tuberculosis Screening**

If student is high risk for exposure documentation of a Tuberculin Skin test (Mantoux) is required within 6 months prior to arrival at Bowdoin College. High risk is defined as prior close contact with a person with TB; being born in Asia, Africa, Latin America, Eastern Europe or Russia; having travelled to any of these regions in the last 5 years; having lived or worked in a nursing home, prison, mental institution, homeless or HIV setting; or history of injection drug use, HIV infection, diabetes, chronic renal failure, immunodeficiency or use of immunosuppressive medication.

Is student high risk? **YES** **NO**

Date PPD placed Date PPD read Result

PPD must be read between 48-72 hours after placement. Students who test positive (>10mm induration) must have a chest x-ray. Copy of chest x-ray report **REQUIRED.** A history of BCG vaccination does not eliminate this requirement.

CXR date Result Report Included?

**HEALTH CARE PROVIDER**

Signature Date

Printed Name and Degree (MD, DO, NP, PA)

**Contact Information:**

Address:

Phone:

Fax:
RELIGIOUS/PERSONAL/MORAL/PHILOSOPHICAL EXEMPTIONS

Bowdoin College and the State of Maine believe that every child and adult should be immunized against preventable diseases.

If you have made the decision not to be vaccinated for religious, personal, moral or philosophical reasons, please sign the statement below:

“For sincere religious, moral, philosophical, or other personal reasons, I am opposed to immunization. If I refuse to be vaccinated or prove immunity to these diseases, I realize that if there is an outbreak of a contagious disease, I will be excluded from school during the danger period (15-23 days).”

Student Signature ___________________________ Printed Name ___________________________ Date ___________________________

Parent Signature ___________________________ Printed Name ___________________________ Date ___________________________

Parent Signature ___________________________ Printed Name ___________________________ Date ___________________________
HIPPA PRIVACY NOTICE ACKNOWLEDGEMENT

"I have been provided an opportunity to receive the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices for Health Services at Bowdoin College."

HIPAA guidelines are posted in the waiting room of Bowdoin College Health Services. Hardcopies are available upon request. Electronic copies are available to view and download on the Bowdoin College Health Services website:


________________________________________
Student Signature

________________________________________
Printed Name

________________________________________
Date