



FISHER COLLEGE

Fisher College Health Services
118 Beacon Street, Boston, MA 02116

Phone: 617-236-8860 Fax: 617-236-5465

Student completes this form. Please return directly to Fisher College Health Services.

PLEASE NOTE: ALL STUDENTS are required to return the HEALTH and IMMUNIZATION REPORT by August 3rd for Fall enrollment and January 4th for Spring enrollment. Students who are admitted after this date must bring their forms to check-in day. Any student failing to provide this required documentation will be prohibited from registering and attending classes.

INSTRUCTIONS: This form must be completed in **ENGLISH**. Please complete all forms labeled ***STUDENT COMPLETES THIS FORM.*** Please have the student's healthcare provider complete and return all forms labeled ***HEALTHCARE PROVIDER COMPLETES THIS FORM.***

Name: _____ Date of Birth: _____
Last First MI Month Day Year

Legal Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Permanent Address: _____
Street and Number City State Zip

E-mail Address: _____ Birthplace (Country): _____

Home Telephone: (_____) (_____) _____ Cell Phone: (_____) _____
Country Code if International Area Code Area Code

Local Address: _____
Street and Number City State Zip

Father/Guardian's Name: _____ Mother/Guardian's Name: _____

Father/Guardian's Home Phone: (_____) _____ Mother/Guardian's Phone: (_____) _____

Father/Guardian's Business Phone: (_____) _____ Mother/Guardian's Business Phone: (_____) _____

Semester/year entering Fisher College: _____ Status: ☐ Freshman ☐ Transfer Living: ☐ Resident ☐ Commuter

College(s) attended: _____ Dates attended: _____

Alternate Emergency Contact

Name: _____
Last First Relationship

Home Telephone: (_____) _____ Cell Phone: (_____) _____

E-mail Address: _____

CONSENT FOR EMERGENCY TREATMENT

To be signed by parent/guardian if student is under 18 years of age:

I give permission for medical treatment for my son/daughter.

In the event of an accident or illness, this includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I am unable to be reached.

Signature Date

CONSENT FOR EMERGENCY TREATMENT

To be signed by student over 18 years of age:

I consent to care at Fisher College Health Services.

Signature Date

FOR HEALTH SERVICES USE ONLY

Allergies: _____

Date Received: _____

☐ Complete ☐ Exemption ☐ Physical Exam

MMR ☐ #1 ☐ #2 IMMUNE ☐

VARICELLA ☐ #1 ☐ #2 CP ☐ IMMUNE ☐

PPD ☐ MCV ☐ TDaP ☐ INFLUENZA ☐

HEP B ☐ #1 ☐ #2 ☐ #3 COVID-19 ☐ #1 ☐ #2 ☐ #3

Please return to Health Services at 118 Beacon Street, Boston, MA 02116



PLEASE RETURN DIRECTLY TO FISHER COLLEGE HEALTH SERVICES

Student Name: _____

Please return directly to Fisher College Health Services.

FAMILY HISTORY

Have any of your immediate relatives had any of the following:

Please list all family members	Age	Health Status	Age at death	Cause of death	Illness	✓ for yes	Specify which relative
Father					Alcoholism/Substance Abuse		
Mother					Asthma or Allergies		
Brothers					Blood or Bleeding Disorder		
					Cancer		
					Diabetes		
Sisters					Heart Disease/ High Blood Pressure		
					Kidney Disease		
					Mental Illness (please specify):		
Spouse					Seizure Disorder		
					Tuberculosis		
Children					Other (please specify):		

STUDENT'S HISTORY

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

- | | | | |
|--|--|---|---|
| 1. ☐ Abnormal Pap | 14. ☐ Frequent ear problems | 27. ☐ Kidney disease/urinary infection | 39. ☐ Testicular problem |
| 2. ☐ Anemia/Bleeding Disorder | 15. ☐ Eye problem | 28. ☐ Learning disability | 40. ☐ Thyroid disease |
| 3. ☐ Anorexia Nervosa/Bulimia | 16. ☐ Fainting | 29. ☐ Malaria | 41. ☐ Tuberculosis |
| 4. ☐ Appendectomy | 17. ☐ Severe head injury | 30. ☐ Recurrent headache | 42. ☐ Ulcer |
| 5. ☐ Arthritis | 18. ☐ Heart disease/problem | 31. ☐ Mononucleosis | 43. ☐ Other serious illness or injury, mental illness (please explain below) |
| 6. ☐ Anxiety | 19. ☐ Heart murmur/click | 32. ☐ Neuro-muscular disease | |
| 7. ☐ Asthma | 20. ☐ Hepatitis/Jaundice | 33. ☐ Phlebitis/deep vein clot | |
| 8. ☐ Bone or Joint Problem | 21. ☐ High blood pressure | 34. ☐ Pneumothorax | |
| 9. ☐ Cancer/Malignancy | 22. ☐ HIV infection | 35. ☐ Positive TB test | |
| 10. ☐ Chickenpox | 23. ☐ Impaired mobility/paralysis | 36. ☐ Rheumatic fever | |
| 11. ☐ Colitis/Ileitis | 24. ☐ Irregular heartbeat | 37. ☐ Seizure disorder | |
| 12. ☐ Diabetes | 25. ☐ Irritable Bowel Syndrome | 38. ☐ Sickle cell disease/trait | |
| 13. ☐ Depression | 26. ☐ Kidney stone | | |

Do you smoke? ☐ No ☐ Yes
How many cigarettes a day? _____ For how many years? _____

Do you drink alcohol? ☐ No ☐ Yes How often? _____
If you drink, how many drinks do you have on the average in one evening? _____

Do you exercise? ☐ No ☐ Yes What type? _____
How often? _____

When you travel in a car, what percentage of the time do you wear a seatbelt? _____ %

Do you wear a helmet when biking/roller blading? ☐ No ☐ Yes

Do you examine your breasts/testicles regularly? ☐ No ☐ Yes

Do you follow any special diet? ☐ No ☐ Yes
What kind? _____

Are you concerned about your eating patterns? ☐ No ☐ Yes
Or your weight? ☐ No ☐ Yes

Do you consider yourself:
☐ underweight ☐ overweight ☐ normal weight

Do you often have a feeling of being overwhelmed or depressed?

☐ No ☐ Yes

Have you ever received treatment or counseling for an emotional problem?

☐ No ☐ Yes

Are you concerned about your own drinking or drug use? ☐ No ☐ Yes

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS:

(If any, provide details including dates, diagnoses, surgeries, etc.)

CURRENT MEDICATIONS:

ALLERGIES (Please specify):

GYNECOLOGICAL HISTORY:

(female students only - check all that apply)

Age at onset of menstrual cycle: _____ Length of cycle: _____

Date of last PAP smear: _____ Result: _____

Have you ever had: ☐ Colposcopy (Date) _____

☐ Irregular periods/no periods ☐ Painful cramps ☐ PID ☐ STI ☐ PCOS

☐ Bleeding between periods ☐ Breast lumps/Fibrocystic Disease

Explain all positive answers (please include dates):

