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 10: 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.**
- ► **Primary care providers, walk-in/urgent care clinics, and most U.S. retail pharmacies 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 practicum 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.**

☐ **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:
  - MMR vaccine: 2 doses OR copy of a blood test showing immunity. (May waive for US birth before 1957.)
  - Hepatitis B vaccine: 3 doses (or 2 doses of Heplisav-B), OR copy of a blood test showing immunity.
  - Varicella vaccine: 2 doses OR copy of a blood test showing immunity OR physician-verified disease. (May waive for US birth before 1980.)
  - Tdap (Adacel or Boostrix) vaccine: 1 dose of TDAP in past 10 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 must be *within 3 months prior to matriculation*.**

- Tuberculosis screening questions must be completed and signed by the student or legally responsible parent/guardian.
- Testing is needed ONLY if a student answers YES to any of the items on the screening questionnaire.

☐ **Page 4: Tuberculosis Medical Evaluation: Complete only if you answer YES to questions on page 3. Date of testing must be *within 3 months prior to matriculation*.**

- Medical provider (MD, DO, NP, PA) review and signature required, if you answer YES to questions on page 3.
- Submit copies of written blood test report(s) and/or chest X-ray report(s), if applicable.
- Tuberculosis skin tests (TST) are not accepted. An IGRA (T-spot or Quantiferon Gold) blood test is required.
- Chest-rays are required for positive IGRA or TST within 3 months of matriculation.

► **UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL.**
(https://smith.medicatconnect.com)

- Online instructions and additional forms are available 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 or FAX 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 | 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 the 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** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

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*
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 3 doses (0, 1 month, 4–6 months apart) **or** 2 doses f Heplisav after age 18 (Specify if Heplisav-B) **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) (*may waive requirement for US birth before 1957*)					
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* (*may waive requirement for US birth before 1980*)					
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.
Student/parent/guardian 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**, the Tuberculosis (TB) Medical Evaluation form on page 4 must be completed.*

		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. Have you ever been a resident, volunteer, and/or employee of a high-risk congretate setting (i.e., correctional facility, long-term care, or homeless shelter) or a health care worker who served clients who are at increased risk for active TB?	☐ Yes ☐ No	_____
4. Were you born in one of the countries listed below?	☐ Yes ☐ No	_____
5. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks?	☐ Yes ☐ No	_____

6. 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	Colombia	Indonesia	Mozambique	South Africa
Algeria	Comoros	Iraq	Myanmar	South Sudan
Angola	Congo	Kazakhstan	Namibia	Sri Lanka
Anguilla	Congo (Democratic Republic of)	Kenya	Nauru	Sudan
Argentina	Cote d'Ivoire	Kiribati	Nepal	Suriname
Armenia	Djibouti	Korea (Democratic People's Republic of)	Nicaragua	Tajikistan
Azerbaijan	Dominican Republic	Korea (Republic of)	Niger	Tanzania (United Republic of)
Bangladesh	Ecuador	Kyrgyzstan	Nigeria	Thailand
Belarus	El Salvador	Lao People's Democratic Republic	Niue	Timor-Leste
Belize	Equatorial Guinea	Lesotho	Northern Mariana Islands	Togo
Benin	Eritrea	Liberia	Pakistan	Tunisia
Bhutan	Eswatini	Libya	Palau	Turkmenistan
Bolivia (Plurinational State of)	Ethiopia	Lithuania	Panama	Tuvalu
Bosnia and Herzegovina	Fiji	Madagascar	Papua New Guinea	Uganda
Botswana	Gabon	Malawi	Paraguay	Ukraine
Brazil	Gambia	Malaysia	Peru	Uruguay
Brunei Darussalam	Georgia	Maldives	Philippines	Uzbekistan
Burkina Faso	Ghana	Mali	Qatar	Vanuatu
Burundi	Greenland	Marshall Islands	Romania	Venezuela (Bolivarian Republic of)
Cabo Verde	Guam	Mauritania	Russian Federation	Viet Nam
Cambodia	Guatemala	Mexico	Rwanda	Yemen
Cameroon	Guinea	Micronesia (Federated States of)	Sao Tome and Principe	Zambia
Central African Republic	Guinea-Bissau	Moldova (Republic of)	Senegal	Zimbabwe
Chad	Guyana	Mongolia	Sierra Leone	
China	Haiti	Morocco	Singapore	
China, Hong Kong SAR	Honduras	Somalia	Solomon Islands	
China, Macao SAR	India			

Source: https://www.acha.org/wp-content/uploads/2024/06/ACHA_Tuberculosis_Screening_May2024.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:

☐ The Tuberculosis (TB) Medical Evaluation form must be completed (page 4).

☐ You are required to have an Interferon Gamma Release Assay (IGRA blood test) or a Tuberculin Skin Test/PPD (TST) **if IGRA is not available**. This must be dated **within 3 months before matriculation.**

☐ If a Tuberculin Skin Test is completed, an IGRA blood test will be required upon arrival.

☐ A CHEST X-RAY is REQUIRED within 3 months of arrival on campus for any positive IGRA blood test or skin tests.

Signature of student **Date**

Required of all students

Signature of legally responsible parent or guardian **Date**

Required of all students under 18 years of age

This page is to be completed by the student/family. 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 who answered YES to any questions on the TB screening form (page 3). Provider signature required.

Last Name_____ **First Name**_____ **Date of Birth** ___/___/____ **Smith ID# 99** _____
MM DD YYYY

TUBERCULOSIS (TB) MEDICAL EVALUATION

Please Note: *Failure to provide complete documentation will result in the inability to travel to campus, register in classes, or participate in college-related events. Any person currently being treated for active TB will be required to provide documentation of treatment and meet with a medical provider upon arrival.* ***Any person being treated for active TB without documentation will not be allowed on campus.***

1. Does student have past or current diagnosis, signs, or symptoms of active tuberculosis disease? ☐ **NO** ☐ **YES**

Students with a history or current diagnosis of active tuberculosis must provide the following:

☐ Documentation from a tuberculosis specialist indicating that the student is **no longer infectious** and including treatment details:
  ☐ Name(s) of medication, dose, frequency taken
☐ Duration of treatment, start date(s) of treatment, date(s) treatment completed
☐ Copies of all sputum results and chest X-rays

2. Interferon Gamma Release Assay (IGRA): ***Required if any YES answers on page 3 or for any positive skin test.***

Type of Test: ☐ TSpot.TB test OR ☐ QFT-GIT ***Must be dated no earlier than March 1, 2025.***
(If Indeterminant, repeat IGRA testing will be required.)

☐ Please attach lab results.
- If IGRA is negative, no further action is required.
- If IGRA is not available, complete section 3 below.
- If IGRA is positive, a chest X-ray is required. Complete section 4 below.

3. Tuberculin Skin Test/PPD (TST): ***Only complete if IGRA testing is not available. Must be dated no earlier than March 1, 2025.*** Please note: An IGRA blood test will be required before starting classes or moving into campus housing.

Date given ___/___/_____ Date read ___/___/_____ **Result:**_____ mm of induration, transverse diameter
MM DD YYYY MM DD YYYY

Interpretation: ☐ **Negative** ☐ **Positive** (Chest X-ray required)

Interpretation of Tuberculin Skin Test guidelines: Interpretation is based on mm of induration and risk factors below.

Risk Factor	Result is considered **POSITIVE** if induration is equal or greater than:
Close contact with an individual with infectious tuberculosis	**5 mm or more**
Born in a country that has a high rate of tuberculosis	**10 mm or more**
Traveled or lived for two weeks or more in a country that has a high rate of tuberculosis	**10 mm or more**
No risk factor (Test not recommended)	**15 mm or more**

4. Chest X-ray: ***Required if IGRA is positive OR if skin test is positive. Must be dated no earlier than March 1, 2025.***

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

If ABNORMAL, consultation with a medical provider is needed for medical clearance prior to arriving on campus.
☐ Attach consultation note

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

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Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.