

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. 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 2019-2020 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

Curry College Health Form

Student Information

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Last Name	First Name	Middle Initial
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Date of Birth	Country of Birth	Gender	Major
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Home Address

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City	State	Zip Code	Country
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Home Phone Number	Cell Phone Number	Email
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Return completed form to:
 Curry College Health Services
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 Milton, MA 02186
 Fax: 617-333-2029
 healthservices@curry.edu

DEADLINES:
 August 2, 2019
 January 3, 2020

Parent/Next of Kin/Emergency Contact

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Name	Relationship
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Address Street	City	State	Zip	Country
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Home Phone	Work Phone	Cell Phone
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NOTE:
 The Health Form is a separate requirement from documentation of student health insurance coverage.

Alternate Emergency Contact

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Name	Relationship
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Address Street	City	State	Zip	Country
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Home Phone	Work Phone	Cell Phone
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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.....Date.....

Medical History

Please list all current medications including dosage

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

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Please list current medical problems

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

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DEADLINES:
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January 3, 2020

Health Care Provider Information

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Health Care Provider Signature Date

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Health Care Provider's Name (please print)

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Address

.....
City State Zip Code

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Phone Number Fax Number

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

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

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

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DEADLINES:

August 2, 2019

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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.

Interferon-Gamma Release Assay (IGRA)	PPD Date Given	Negative	PPD +, Chest X-Ray Result		PPD+ with x-ray negative	Length of Tx
Date:						
Result:	Date Read	Positive	Negative	Positive	Prophylactic Medication	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	Titer Date Result	
Measles, Mumps, Rubella, (MMR) Dose 1 on or after 1st birth-day	Date of Dose #1	Date of Dose #2	Measles Titer Result	Mumps Titer Result	Rubella Titer Result
Meningitis (MenACWY) On or after 16th birthday	Date of Dose	Signed Waiver Form (see attached)	Meningococcal Serogroup B (MenB) Recommended	Date:	
Tdap (Tetanus, Diptheria, and Acellular Pertusis)	Date				
Varicella Dose 1 on or after 1st birth-day	Date of Dose #1	Date of Dose #2	Titer Date Result	Date of Disease	