Past and Present Medical History

To be completed by applicant and verified by the examining physician. Check every blank. Attach extra pages if necessary. YOU MUST BRING THIS COMPLETED FORM TO BE REVIEWED DURING THE PHYSICIAN'S EXAM.

Student Name: _____
Date of Birth: _____
Physician's signature verifying content of this form:_____

Conditions and symptoms - Do you have, or have you had any of the following?
Explain any "yes" answers in Section B.

	yes	no		yes	no
1. Appendicitis			2. Asthma		
3. Bronchitis			4. Chicken Pox		
5. Epilepsy			6. Scarlet Fever		
7. Severe Injuries (specify location and type)			8. Joint Problems (specify location and type)		
9. Sore Throat			10. Hay fever		
11. Hernia			12. Intestinal Parasites		
13. Measles			14. Mumps		
15. Polio			16. Pneumonia		
17. Sinus Infection			18. Tuberculosis (TB)		
19. Typhoid Fever			20. Whooping Cough		
21. Anorexia Nervosa			22. Bulimia		
23. High Blood Pressure			24. Heart Disease		
25. Irregular Heart Beat			26. Hepatitis (specify type)		
27. Bleeding Disorder			28. Diabetes		
29. Cancer			30. Frostbite		
31. Circulation Problems			32. Abdominal Pains		
33. Frequent Colds			34. Constipation		
35. Convulsions			36. Frequent Dizziness		
37. Frequent fainting			38. Headaches		
39. Heat exhaustion/stroke			40. Hives		
41. Indigestion			42. Migraines		
43. Nose Bleeds			44. Sleep Walking		
45. Stomach Ulcers			46. Bladder Infection		
47. Kidney problems			48. Thyroid problems		
49. Intestinal problems			50. Endocrine problems		
51. Immune sys. problems			52. Hearing impairment		
53. Vision Impairment			54. Motion sickness		
55. Broken bones			56. Spinal Injury/problems		
57. Nervous System Disease			58. Muscle cramps		
59. Temperature tolerance problems			60. Recent exposure to infectious disease		
61. Active bedwetting			62. Diphtheria		
63.Seizure Disorder			64. Skin problems		
65. Unexpected weight loss			66. Frequent shortness of breath		
67. Back/Neck problems			68. Arm/Shoulder problems		
69. Leg/knee/foot problems			70. Special Diet		
71. Currently pregnant			72. Chronic cough		

B. Condition Details -- If you answered "yes" to any of the above items, please explain below. Include the following: What specific symptoms are occurring; How long symptom lasts and how often symptom/condition occurs; Date of last occurrence; How symptom/condition affects your activities, including ability to hike and live outdoors.

Item #	Detailed description (including restrictions, if any)

For the Physician's Exam

Please review the student's completed Medical History form and make any corrections or additions. Then complete this form, filling in all spaces. **PLEASE WRITE LEGIBLY** and attach extra sheets as is warranted. Thanks for your help.

Patient's Name _____ Date _____

Height _____ft _____in Weight _____lbs. Date of Birth _____

Age _____ Blood pressure _____/____ Pulse Rate _____ Pulse irregularities? _____

How long have you known this patient? _____

A. Exam -- Check if normal.	**Describe ONLY if abnormal.**
Eyes (lenses needed?)____[ ]	_____
Ears/Hearing_____[ ]	_____
Nose _____[ ]	_____
Throat and Mouth _____[ ]	_____
Tonsils _____[ ]	_____
Teeth (General condition)_[ ]	_____
Neck _____[ ]	_____
Thyroid _____[ ]	_____
Thorax & Lungs_____[ ]	_____
Heart _____[ ]	_____
Circulation _____[ ]	_____
Abdomen _____[ ]	_____
Hernia check_____[ ]	_____
Genitals/Urinary Tract____[ ]	_____
Back _____[ ]	_____
CNS _____[ ]	_____
Lymph Nodes _____[ ]	_____
Skin _____[ ]	_____
Scars _____[ ]	_____
Extremities _____[ ]	_____
Shoulders _____[ ]	_____
Knees _____[ ]	_____
Ankles _____[ ]	_____
Feet _____[ ]	_____

Other _____

B. Medical Restrictions -- Check each line, list details below.	yes	no	which activities?
Are there any activities from which the patient must abstain?	[ ]	[ ]	_____
Are there any activities which should be limited?	[ ]	[ ]	_____
Are swimming and diving okay for this patient?	[ ]	[ ]	_____

Summary of Active Medical Restrictions -- None [ ] or list below:

_____

_____

C. Emotional and mental status

Does this patient have any condition that could present any endangerment to the health, welfare, or morale of this patient or other community members? Please explain. _____

_____

D. Allergies (Including medicines, food, bites, animals, and stings). Check here [ ] if none.

Allergy -- list below	Reaction	Medication required

E. Medications - List what medications the patient is using, including psychiatric and over-the-counter meds. Check here [ ] if none.

Medication	Taken for: Condition/Symptom	Dosage (size and freq.)	Date Started	Current Side Effects

G. Hospitalizations -- List any hospital or emergency department visits w/in the last two years. Check here [ ] if none.

Dates	Reason	Length of stay

H. Statement of Verification of Patient Exam -- Physician must read and sign.

The "Past and Present Medical History" form and "For The Physician's Exam" form are part of this patient's process for participation in the Guyana Lesley Abroad Service Semester (GLASS) Program at Lesley University. Activities may include hiking/backpacking, camping, canoeing, and traveling in remote areas where complete medical care may not be immediately available. Students must be fit and healthy to be comfortable on this program. There are sudden tropical weather extremes, unplanned changes in meal routine and diet, travel and exposure in conditions of high heat and humidity and biting insects, always in a close-knit and busy group atmosphere. In light of this knowledge about the GLASS program, please complete the following verification statement. If you, as the examining physician, do not feel this patient is able to participate in this program please provide the patient with a legible written statement of your concerns, or call the Lesley College Natural Science and Mathematics Division Director to discuss and elaborate on your concerns at 617-349-8226 or email: morimoto@lesley.edu.

I have examined (patient) _____ on (date) _____ and to the best of my knowledge, this individual's health is good, and he/she should be physically and emotionally able to enter into all Guyana Lesley Abroad Service Semester activities. I have indicated on these forms past and present medical conditions and data of which I am aware pertaining to this patient.

Signed: _____ Phone number: _____

Print Physician's name here: _____

Physician's Address: _____

LESLEY UNIVERSITY
Certification of Immunizations
2007-2008

Massachusetts State Law mandates that full time students in Massachusetts provide the following proof of immunization certification.

Your completed form, signed by a physician or nurse, should be mailed *before your arrival on campus* to:
Student Insurance Office, Division of Student Life and Academic Development, 29 Everett Street, Cambridge, MA 02138
If you have any questions about this form, please contact the Student Insurance Office at (617)349-8543, fax (617)349-8558 or **studentinsurance@lesley.edu**.

Please type or print all information. It is very important that *ALL* information is complete and legible.

Name: _____
First Middle Last
Address: _____
Street Apt. No.
_____
City State Zip
Daytime Phone: _____ Home Phone: _____

SSN or Student Account ID: _____ Date of Birth: _____

Check one:
☐ **Art Institute of Boston** ☐ **Grad. School of Arts and Social Sciences**
☐ **School of Education** ☐ **Threshold** ☐ **Lesley College**

Required Immunizations - Please have your nurse or physician complete and sign this section.

MMR Requirement	Date First Vaccine Given	Date of Second Vaccine Given	Date of Positive Serological Test
MMR			

The MMR Requirement consists of: 2 MMRs (Measles, Mumps and Rubella) given after the 1st birthday and at least one month apart.

Tetanus Diphtheria	Date of last dose given (must be within 10) Years)
TD Booster	
OR	//////////////
Tdap	

The date of the last dose given must be within the past ten (10) years.

Hepatitis B	Date Given
1st Dose	
2nd Dose	
3rd Dose	

The second dose of Hepatitis B must be given no sooner than one (1) month after the first dose. The third dose must be given no sooner than five (5) months after the second dose. A titer or serological test date can also be provided for Hepatitis.

Meningitis	Date Given
Meningococcal Vaccine	

Please review the information about Meningitis attached, or on our website: (www.lesley.edu/services/student_insurance). Students who will be living on campus are REQUIRED to either document that you have had the vaccine within five years, or sign the official waiver form stating that you understand the risks and choose not to receive the vaccine.

_____
Physician/Nurse Signature (REQUIRED) **Date**

_____
Physician/Nurse Office Phone Number **Fax**

IMPORTANT NOTE: Keep a copy of your Certification of Immunizations for your own records.
IMMUNIZATION EXEMPTION: You may be considered exempt from the above immunizations if you have a documented medical condition or religious belief that prohibits you from receiving the immunizations. If this pertains to you, please contact the Insurance Office at **studentinsurance@lesley.edu.**