Health Services Forms and Information

You and your parent(s)/guardian(s) need to read the attached information carefully, and complete all necessary forms. (These health forms are also available on our website as a separate document under Forms for New Students). Massachusetts state law requires that the Health Services Office have your completed insurance and health information forms (including completed Massachusetts immunization forms) on file before you can move into the residence halls and attend classes.

Please complete and return the following forms as soon as possible and no later than July 15th for students entering in the fall and January 1st for students entering in the spring.

To be completed by a physician:

Physical Examination, Immunization Records, and EpiPen form (if applicable) on pages 29-31. **Immunizations required for college students in Massachusetts may differ from your state of residency; those listed on page 30 are required unless otherwise noted. If you are missing any of the required immunizations, you need to receive them prior to your arrival on campus.** If your physician does not have your complete immunization record, please obtain records from your current school and/or previous provider.

To be completed by the student and their family:

With the exception of the Physical Examination and Immunization records, all forms should be completed by the student and their family. Be thorough in completing all forms—the information you submit is necessary for us to care for you if you become ill on campus, and to support your ongoing health and well-being.

Please feel free to contact Health Services directly if you have any questions at 413-528-7353 or healthservices@simons-rock.edu or visit their webpage on our website.

Please return the completed forms to:
Office of Admission • Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 800-235-7186     F: 413-541-0081
MEDICAL ALERT CONDITIONS

I have this “Med-Alert” Condition: ____________________________

I have been prescribed an EpiPen: Yes ☐ No ☐ If yes, EpiPen form must be completed by your physician and returned.

On-going Chronic Illness: ____________________________

List Medication Allergies: ____________________________

List Other Allergies: ____________________________

SCREENING QUESTIONS FOR STUDENT

1. Do you have physical limitations? ____________________________ Yes ☐ No ☐

2. Are you now receiving or have you ever received treatment or counseling for mental health illness? ____________________________ Yes ☐ No ☐

3. Have you had any serious illness, surgery, or been hospitalized? ____________________________ Yes ☐ No ☐

4. Are you taking any medications or supplements regularly? ____________________________ Yes ☐ No ☐

   If yes, name: ____________________________

5. Do you have any health concerns that you would like help with while on campus? ____________________________ Yes ☐ No ☐

   If yes, explain: ____________________________

6. If you are interested in receiving counseling at Simon’s Rock please call 413-528-7353 to arrange an appointment.

PERSONAL MEDICAL HISTORY

Check the box below if your son/daughter has had any problems in the following areas. Comment on all checked boxes in the space provided (attach an additional sheet if needed).

☐ Childhood Illnesses (scarlet fever, German measles, mumps, chicken pox, rheumatic fever, etc.): ____________________________

☐ Head/Neurological (headaches, migraines, seizures, head injury, etc.): ____________________________

☐ Ears, Nose, Throat, Mouth (ear infections, hearing loss, sinusitis, strep throat, tonsillitis, dental issues, braces, etc.): ____________________________

☐ Eyes (visual impairment, contact lenses or glasses, infections, etc.): ____________________________

☐ Heart (palpitations, dizziness, fainting, arrhythmia, high/low blood pressure, etc.): ____________________________

☐ Lung (shortness of breath, chest pain, asthma, infections, cough, etc.): ____________________________

   □ My child has had a positive skin test for tuberculosis (TB)

☐ Musculoskeletal (broken bones, dislocation, scoliosis, hernia, weakness, paralysis, etc.): ____________________________

☐ Gastrointestinal/Metabolic (abdominal pain, diarrhea, constipation, weight gain/loss, diabetes, etc.): ____________________________

☐ Genital/Urinary (Urinary tract infections, kidney stones, gynecological problems, etc.): ____________________________

☐ Skin (rash, eczema, herpes, etc.): ____________________________

☐ Psychological (ADHD, mood disorder, eating disorder, sleep problems, etc.): ____________________________

Please provide additional information on checked boxes including diagnosis, treatment and dates. (Use a separate sheet.)
The following pages need to be filled out by the student and a parent or guardian (if the student is a minor) with the exception of the physical exam and the immunization pages. **If there are any changes to this information during the academic year please notify Health Services.**

### STUDENT IDENTIFICATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
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<td>Home Address</td>
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<td>City</td>
<td>State</td>
<td>ZIP</td>
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<tr>
<td>Home Phone (with area code)</td>
<td>Cell Phone</td>
<td>E-mail</td>
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<tr>
<td>Social Security Number</td>
<td>Date of Birth</td>
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<td>Country of Citizenship</td>
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### NOTIFY IN EMERGENCY (parent/guardian)

Name and Relationship

Home Address of Person to Notify

Home Phone (with area code) | Work Phone

Cell Phone | E-mail (home/work, whichever is checked frequently)

### NOTIFY IN EMERGENCY

Name and Relationship

Home Address of Person to Notify

Home Phone (with area code) | Work Phone

Cell Phone | E-mail (home/work whichever is checked frequently)
MEDICATION AGREEMENT

For students living on campus, it is often easier to have existing prescriptions filled at a local pharmacy. Village Pharmacy in Lenox delivers medications to Simon’s Rock’s Health Services daily. There are other pharmacies available in Great Barrington, if students choose to obtain prescriptions outside of Health Services.

STUDENT AGREEMENT FOR SELF- ADMINISTRATION OF MEDICATIONS

- I understand that I am responsible for following my doctor’s directions for taking my medications.
- I will safely store prescribed and over-the-counter medication(s) in my room while at school.
- I will keep the medication in the original pharmacy-prepared container/package so that it can be easily identified if necessary.
- I agree to contact an adult on campus if I have an issue with medication.
- I agree to NEVER share my medication with another student.
- I will report lost or stolen medication to Security or Health Services immediately.
- I understand that if I do not follow the above agreements I may be subject to College disciplinary action.
- By signing below, I understand and agree that it is my responsibility to ensure that my prescribed medication(s) are being administered in accordance with my medical provider(s)’ order(s).

__________________________  __________________________  ____________
Student Signature  Print Name  Date

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATIONS

I give permission for my son/daughter to self-administer prescribed as well as over the counter medications. I understand and agree that it is my son/daughter’s sole responsibility to ensure that his/her medication(s) are being administered in accordance with his/her medical provider(s)’ order(s) or the manufacturer’s directions. I understand and agree that the College is not responsible for my son/daughter’s failure to follow prescribing orders or for the consequences of such failure.

__________________________  __________________________  ____________
Parent/Guardian Signature  Print Name  Date

CONSENT FOR OTC MEDICATIONS

In order that students have ready access to over the counter medications (Tylenol, Ibuprofen, Benadryl) when Health Services is closed, please read and sign below.

I give permission to the staff residence directors to give my son/daughter, an over-the-counter medication, as requested by my son/daughter or as recommended by the on-call medical provider.

__________________________  __________________________  ____________
Parent/Guardian Signature  Print Name  Date
Confidential Sharing Agreement and Consent for Treatment

The College assures that medical information will be regarded as confidential and shared only as necessary for the student’s immediate safety. **Minor students (under 18 yrs.) cannot remain on campus** until Health Services receives a signed Consent for Treatment form.

I hereby give my permission for the medical staff at Bard College at Simon’s Rock Health Services and their off site medical providers to provide and share medical information as needed for the medical treatment of my daughter/son during the time they are enrolled as a student at the College. Furthermore, I give my permission to Bard College at Simon’s Rock to arrange for or provide transportation for my child to receive medical treatment. In case of an emergency, I give my permission for transportation and treatment of my child at a medical facility which may include: ambulance transport, medical treatment, psychiatric evaluation and/or treatment, and when necessary, hospitalization.

Signature of Parent/Guardian (required if student is under 18 years of age)  
Date

MEDICAL ALERT/MEDICATION ALLERGIES  

**Insurance Information**

All students are required to purchase the college health insurance.  
**Family insurance will be used as necessary.**

**College Health Insurance**

*Consolidated Health Plans, 195 Stafford Street, Springfield, MA 01104*  
413-733-4540

Do you have health insurance coverage under a family or individual policy?  
☐ yes  ☐ no

*IF YES, PLEASE ATTACH A COPY OF YOUR HEALTH INSURANCE CARD*

Please attach a copy of the FRONT of your insurance card here

Please attach a copy of the BACK of your insurance card here

*SUBSCRIBER’S NAME:_________________________________ D.O.B. _____________________

*INSURANCE COMPANY:__________________________ INSURANCE ID# __________________
**Physical Exam Record**

Simon’s Rock requires a physical exam within the last 12 months for all current students. Please have your history reviewed by your health care provider and have them fill out the information below. **State regulation mandates that Health Services be in possession of relevant health records before a student assumes residency at the College. Include copies of any other records you feel pertinent.**

Name (print): ................................................................. (last) ................................................................. (first) ................................................................. (middle)

Date of Birth: ____________________ Date of Examination: ____________________

Height*: ______________ Weight:* ______ * Please note any changes in the past year

Blood Pressure: ______________ Pulse: ______________ Medication allergies: ______________

Hgb or Hct: ______________

Current Medications: ____________________________________________________________

This individual has been prescribed an EpiPen: Yes ☐ No ☐ If yes, EpiPen form must be completed and returned.

Please check if normal and explain otherwise.

☐ HEENT __________________________________________  ☐ Abdomen____________________

☐ Neck___________________________________________  ☐ GU____________________

☐ Thyroid________________________________________  ☐ Hernia/Pilonidal cyst ____________

☐ Lungs___________________________________________  ☐ Extremities____________________

☐ Breast__________________________________________  ☐ Gyn____________________

☐ Cardiac_________________________________________  ☐ Spine____________________

☐ Emotional/Psychiatric ________________  ☐ CNS____________________

Is this individual capable of unlimited physical activity? If not, please explain.

Significant past medical/psychiatric history:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Healthcare Provider Signature: ____________________ Print Name: ____________________

Address: ________________________________________________________________

Telephone: (____)________________________ Fax: (____)__________________________

Please return the completed form as soon as possible to:

Office of Admission | Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
800-235-7186 • Fax 413-541-0081
# MASSACHUSETTS REQUIRED IMMUNIZATION HISTORY

This form must be signed by a physician. State regulation mandates receipt of health records before students reside on campus.

## REQUIRED IMMUNIZATIONS:

### TETANUS/DIPHTHERIA/ACELULAR PERTUSSIS

(Tetanus must be within the last 10 years)

Primary series

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Tdap ___/___/___

| MM | DD | YY |

### MEASLES, MUMPS, RUBELLA (MMR) 2 doses required.

MMR #1 ___/___/___ (First dose must be after age 12 months)

| MM | DD | YY |

MMR #2 ___/___/___ (Must be at least one month after dose #1)

| MM | DD | YY |

### MENINGITIS VACCINE *

#1 ___/___/___  

Booster #2 ___/___/___  Required within the last 5 years

### VARICELLA (2 required)

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OR  

Had the disease ___/___/___

| MM | DD | YY |

### HEPATITIS B

#1 ___/___/___  

#2 ___/___/___  (Must be at least 1 month after #1)

| MM | DD | YY |

#3 ___/___/___  (Must be at least 2 months after #2 and 4 months after #1)

| MM | DD | YY |

## RECOMMENDED IMMUNIZATIONS:

### Human Papillomavirus Vaccine:

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### Polio Primary Series:

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booster  

| #4   | MM | DD | YY |

### Tuberculosis testing: A mantoux is only required for students determined to be at high risk for tuberculosis. A chest film is required for any positive PPD  PPD Date ___/___/___ mm_____  chest X ray_____

Treatment dates____________________________________________________________________________

### Physician Phone number________________________ Fax number___________________________________

Address___________________________________________________________________________________

Physician’s Signature_____________________________  Date_______________________________

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EpiPen Form

This form is to be completed by the physician prescribing the EpiPen.

Name of Student: ___________________________ Date of Birth: ___________________________

Identified allergens: ________________________________________________________________

Date of first allergic reaction: _______________________________________________________

Symptoms experienced: _____________________________________________________________

Initial symptoms requiring EpiPen treatment: ____________________________________________

Number and type of subsequent reactions: _____________________________________________

Number of episodes when EpiPen was administered: ______ Date of most recent administration: __________

Have any allergic reactions required hospitalization? Yes □No□ If yes, please describe

Has this student received training on self-administration of the EpiPen? Yes □No□

If yes, date: __ Have they ever self-administered the EpiPen? Yes □No□

Method of allergy testing: Blood □Skin □

Asthma: Yes □No□

Current allergy treatment: __________________________________________________________

______________________________________________________________

Prescription for EpiPen use: □Autoinjector □0.15mg □0.30mg □Twinject

Other treatments to be administered?

______________________________________________________________

Is there any other information that may be useful in treating this student?

______________________________________________________________

Healthcare Provider Signature: ___________________________ Print Name: ___________________________

Date: ___________________________ Phone: ___________________________

If applicable, please return the completed form to: Office of Admission • Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 1-800-235-7186    F: 413-541-0081
HEALTH SERVICES
Consent and Information Form
(For student to read and sign)

General Information
Health Services is available to all currently enrolled Simon’s Rock students who have paid the student health insurance fee. The Health Services’ hours of operation are Mon-Fri. 9am-5pm. The Health Services office is closed on weekends and during all school vacations.

Urgent Care and Emergency Services
Health Services provides urgent care coverage for weekends and nights when school is in session through an on-call nurse. The on-call nurse can be contacted through the Resident Directors or Security.

Making appointments
Walk in appointments are always welcome and we will do our best to see you as soon as possible. Appointments can be booked through the Administrative Assistant for a specific nurse, the Nurse Practitioner, or Physicians.

Health Insurance/Cost
All medical care provided at Health Services will be covered by the school health insurance. The school health insurance will cover medication prescriptions issued from Health Services and outside providers with a copay which is charged to student’s account. In the event you are referred to an outside provider or have an Emergency Room visit, your home insurance and the school health insurance will be billed. For further information regarding the school health insurance, contact Consolidated Health Plans at 800-633-7861 (consolidatedhealthplan.com) or the Health Services at 413-528-7353.

Confidentiality
Privacy of your health information is one of our top priorities. Other than as described in Exceptions to Confidentiality, no one outside of Health Services staff will have access to your medical information including parents, faculty, student life staff, other students, or school administration without a student’s explicit written permission. To maintain continuity of care, all Health Services personnel will have access to your medical record. If you are referred to a medical provider outside of Health Services, medical information regarding the specific referral will be shared with the outside provider. Basic medical information will be shared with insurance companies to facilitate billing. If the student and provider deem it necessary to share medical information with someone outside of Health Services, this includes Counseling Services, a student will be asked to sign an authorization form to release the information. Voice mail and e-mail communications to students will not include personal health information to maintain privacy.

Collaborative Treatment and Shared Space
The Health and Counseling Services offices reside together in the Student Union. Our philosophy of practice assumes an integrated, whole person approach which includes sharing relevant health information in order to create a coordinated plan to best support a student’s wellness.

Exceptions to Confidentiality
There are some exceptions to confidentiality. In situations in which there is evidence of a threat of serious harm to oneself or another, the medical staff is required to take action/disclose information to protect the person at risk of harm. When there is information about, or strong suspicions of physical or sexual abuse or neglect of a minor, this must be reported to the Department of Social Services. In certain legal situations, including court order, a medical provider may be required to disclose information. In addition, any time a student is admitted to the Emergency Room, the medical staff will contact the student’s parents. This is a policy of Bard College at Simon’s Rock and is in the student handbook.

I have read and understand the information above.

Student Signature: ____________________________ Date: _________________