Dear New Student:

The Maryland Institute College of Art (MICA) requires a completed health history form. This form includes your health history, a physical examination, and your immunization history. Up-to-date immunizations are required for all new students. Please complete your portion of the enclosed form and have your primary care provider complete the physical examination and immunization history sections. Additionally, *optiona*l the Medical Provider Request & Consent for Continuity of Medication Management form is enclosed. **Please submit these form(s) by Friday July 31, 2020 to MICA Student Health Services via email to healthservices@mica.edu or fax to 410.225.0252.**

Students are required to provide a copy of a current immunization record at the time of the visit and any expenses related to the physical exam, immunizations or lab work that is not covered by the student's insurance plan will be the responsibility of the student. All health records are confidential. Students who are not of legal age (18) upon arrival to MICA will be required to have a release for treatment form signed by a parent or guardian.

Please note that all students are expected to maintain active, comprehensive health insurance coverage that is accepted in the state of Maryland while enrolled at MICA.

Kaiser Permanente, Jai Medical Systems, Bravo, and Tricare (active duty) policies are not accepted at MICA Student Health Services. Please call your insurance company to verify your coverage in the state of Maryland.

REQUIRED immunizations:

1. **Tetanus and Diphtheria**: Td/Tdap within 10 years of enrollment.
2. **Measles, mumps, and rubella** vaccination dates or titer. According to guidelines from the Center for Disease Control, history of disease is not adequate unless you were born before 1957.
3. **Tuberculosis Screening**: Mandatory PPD screening for all students, regardless of previous BCG.
4. **Meningococcal** vaccine or waiver for all students living in campus housing. Please see attached information related to this vaccination requirement.

RECOMMENDED immunizations:

1. Hepatitis B series -- 3 dose vaccine series.
2. Hepatitis A series – 2 dose vaccine series.
3. Chickenpox (Varicella) -- 2 dose vaccine series or a titer representing history of disease and immunity. Documented history of disease by a medical provider with month/year is acceptable.
4. Human papillomavirus vaccine series -- 3 dose vaccine series for females under the age of 27/males under the age of 21 (unless medically indicated).

Should you need additional information or clarification regarding the health history form, please feel free to call MICA Student Health Services at 410-225-4118 or visit https://www.mica.edu/student-resources/student-health-services/ to access additional information and health-related forms.

Best wishes and we look forward to working with you during your time at MICA.

Catriona Henderson, RN/BSN
Clinic Manager
MICA Student Health Services by Chase Brexton

MICA Student Health Services is located at 1501 W. Mt. Royal Avenue. The clinic offers routine medical examinations, screening for specific diseases, and preventive services (e.g. gynecological exams including pap smears), as well as sick/urgent care visits. If you have a chronic medical condition, please plan to schedule an appointment with a provider soon after arriving to campus so that we can best coordinate your care while in school. Please bring your insurance card with you to all visits as all tests, screenings, procedures, and medications will be billed to your insurance company.

Medical Provider Request and Consent for Continuity of Medication Management

MICA
Student Health Services
by Chase Brexton

Patient Name: _____ DOB: _____ Today's Date: _____

Dear Provider:

The staff at the **MICA Student Health Services** is pleased to assist your patient with medication management while attending school in Baltimore, Maryland. In order to provide safe and appropriate care, we request that you forward the last two office notes related to the medication(s) indicated below for our records. Please indicate on the form below the frequency of office visits to the MICA Student Health Services that you recommend, as well as any special instructions for medication monitoring (i.e – lab work, urine toxicology screening). We will require that the student return to your office at least annually for routine follow-up or at the interval agreed upon between you and the student. We defer all dose adjustments to you unless there is clear communication with our office regarding a change in the plan of care. Please do not hesitate to contact MICA Student Health Services so that we may best coordinate care for this student.
Thank you,

Catriona Henderson, RN, BSN
RN Clinic Manager, MICA Student Health Services

****

Medication #1 _____
Sig: _____:_____
Recommended frequency of office visits: _____
Special instructions: _____

Medication #2 _____
Sig: _____:_____
Recommended frequency of office visits: _____
Special instructions: _____

Provider Name (print) : _____ **Date:** _____

**** Provider Signature:** _____ **

Telephone number: _____ **Fax number:** _____

This consent will expire one year from the date of provider signature

Please fax the consent, the last two office notes, and a signed Release of Information for future communication to the MICA Student Health Services

MICA Student Health Services by Chase Brexton

Registration Information

Personal Information

Legal Last Name _____ Legal First Name _____ Middle _____

Social Security Number _____ Date of Birth _____ Marital Status _____ Sex: F M Transgender

Home Address (number and street) _____ City or Town _____ State _____ Zip Code _____

Home Telephone Number _____ Cell Phone Number _____

Preferred language (if other than English) _____

Emergency Contact Information

Name 1: _____ Relationship: _____

Home phone: _____ Work/Cell Phone: _____

Name 2: _____ Relationship: _____

Home phone: _____ Work/Cell Phone: _____

Insurance Information

Medical Insurance: _____ Member #:_____ Group #:_____

Policy Holder Name: _____ Policy Holder Date of Birth: _____/_____/_____

Address to send claims (if different than home address): _____

If available, please attach a copy of the front and back of insurance card

Additional Information

Race: American Indian/Alaskan Native_____ Asian _____ Black/African American _____ Hispanic/Latino _____ Multiracial _____
Native Hawaiian/Pacific Islander _____ White_____

Country of Origin (if not United States): _____

Veteran: Yes _____ No _____

Authorization for Treatment of Minors (if applicable)

If the student has not yet reached their 18th birthday before the beginning of the academic year for which the student is registered, the following authorization by a parent of legal guardian is required.

I hereby authorize my son/daughter to be treated at MICA Student Health Services if needed, and in case of emergency and in the event that I am unavailable, to be taken to the nearest emergency care center or hospital for appropriate medical treatment.

Parent/Legal Guardian: _____ Date: _____

For Office Use Only:

_____ Meningococcal vaccine received or waiver signed

MICA Student Health Services by Chase Brexton

Date _____

Legal Name (Last, First, Middle) _____ Date of Birth _____/_____/_____

Personal Health History

To be completed by student and reviewed by healthcare provider. All information included in this form is confidential and strictly for the use of MICA Student Health Services. Information on this form will not be released to anyone without the knowledge and consent of the student.

Personal History: Part I			
Question	Yes	No	If you select yes, please provide details.
Please list all diagnosis for which you have been treated/ hospitalized/ received daily medication/ accessed specialty care.			
Have you had surgery? (For example, appendectomy, tonsillectomy, hernia repair, etc.)			
Do you take medication, pills, or use other drugs regularly? Please attach list if applicable.			
Are you allergic to any medicine? If yes, please list medication and allergic symptom.			
Do you have allergies to food, insects, stings, or other materials?			
Do you have any handicap which requires assistance in evacuation in case of an emergency in a classroom or other space?			
Have you received treatment or counseling for stress, nervous condition, personality or character disorder, or emotional problems?			
Please list the name, specialty and office telephone number of any consulting providers by whom you are currently being treated.			

MICA
Student Health Services
by Chase Brexton

Personal History: Part II								
Have you had?	**Yes**	**No**	**Have you had?**	**Yes**	**No**	**Have you had?**	**Yes**	**No**
Eczema			Shortness of breath			Recurrent vomiting		
Acne			Asthma			Recurrent constipation		
Head injury with unconsciousness			Chronic cough			Unplanned weight gain (>20 lbs)		
Tumor, cancer, or cyst			Cystic fibrosis			Unplanned weight loss (<20 lbs)		
Dizziness or fainting			Chest pain			Hernia		
Eye trouble			Palpitations (heart)			Hemorrhoids		
Ear problem			Rheumatic fever			Do you drink alcohol?		
Hearing difficulty			Heart murmur			Do you use street drugs?		
Nose problem			High blood pressure			Back problems		
Sinusitis			Low blood pressure			Disease or injury of joints		
Hayfever			Anemia			Recurrent Bladder infection		
Gum or tooth trouble			Sickle cell			Kidney infection		
Throat problem			Bleeding disorder			Weakness or paralysis		
Neck injury			Gastric Reflux			Seizures		
Do you smoke cigarettes?			Irritable Bowel Syndrome			Recurrent headaches		
Bronchitis			Gall bladder trouble			Insomnia		
Do you use marijuana?			Jaundice			Frequent anxiety		
Pneumonia			Hepatitis			Frequent depression		
Tuberculosis			Recurrent diarrhea			Worry or nervousness		
Mononucleosis			Malaria			Sports enhancing drugs		
Sexually transmitted disease			Diabetes			Thyroid problem		
Herpes								
Females only								
Irregular periods			Severe cramps			Excessive flow		
Abnormal pap			Pregnancy			Cystic breasts		
Males only								
Prostate problems			Lump or mass in testicle					

MICA
Student Health Services
by Chase Brexton

Family History				
	Age	Health Status	Health history	Age/Cause of Death (if applicable)
Mother				
Father				
Sibling				
Sibling				
Sibling				

Are you adopted? Yes _____ No ____

Family Illness History - Have any of your blood relatives (parents, siblings, grandparents) ever had any of the following?			
Affliction	Yes	No	Relationship
Bleeding disorder			
Tuberculosis			
Diabetes			
Kidney disease			
Arthritis			
Stomach disease			
Asthma			
Hay fever			
Heart attack/disease			
Epilepsy			
Convulsions			
Cancer			
High blood pressure			
Stroke			
Suicide			
Alcoholism/addiction			
Hyperlipidemia			
High cholesterol			

The information that I have provided on this health form is accurate, to the best of my knowledge. I understand that all information is maintained as confidential within the MICA Student Health Services.

Student Signature Date

MICA
Student Health Services
by Chase Brexton

Physical Examination

This portion should be completed by a physician. Please review the student personal health history form and comment on any positive responses.

Legal Name (Last, First, Middle) _____ Date of Birth _____ Biological gender M/F

Blood Pressure _____ Heart Rate _____ Height (in) _____ Weight (lbs) _____ Urine sugar/protein (Y/N)

Vision: Right 20/ _____ Left 20/ _____ Both 20/ _____ **Circle one:** With correction Without correction

System Abnormalities		
System	**Yes**	**No**
Head, ears, nose, or throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/endocrine		
Neuropsychiatric		
Skin		

Are there any abnormalities of the systems listed on the left? Describe.

_____

_____

Your recommendations regarding the care of this student would be appreciated.

_____

_____

Is the student now under treatment for any medical or emotional condition?

_____

_____

Fitness Participation

Is the student physically fit to begin a new exercise routine or modify their current one to include the following (mark all that apply):

Resistance training _____ Flexibility training _____ Cardiovascular training _____ Contact sports ____

☐ I am not aware of any contraindications toward participation in an exercise program _____

☐ I believe the student can participate, but urge caution because _____

☐ The applicant should not engage in the following activities _____

☐ I recommend my patient not participate in any of the above activities _____

MICA Student Fitness Center staff is available to discuss modified fitness/exercise programs if requested.

Please complete attached student vaccination record.

Physician's Name _____ Physician's Signature _____ Date _____

Address _____ City/Town _____ State _____ Zip Code _____

Telephone _____ Fax _____

MICA
Student Health Services
by Chase Brexton

Student Immunization Record

(Form must be completed and returned before registration.)

To be completed by the student:

_____
Last Name First Name Middle Initial

_____ **M F**
Date of Birth Social Security Number Biological Sex (circle)

MANDATORY IMMUNIZATIONS FOR MICA REGISTRATION

To be completed and signed by a health care provider. (Dates must include month, day, and year)

M.M.R. (Measles, Mumps, Rubella) **OR** **M.M.R. Titer** (Measles, Mumps, Rubella)

Option 1

Dose 1 – Immunized at 1 year or after
_____/_____/_____

Dose 2 – At least 4 weeks after dose 1
_____/_____/_____

Option 2

Lab report of titer _____

Copy of report must be attached

Tetanus-Diphtheria
(Td Booster within last 10 years)

TD _____/_____/_____

Or

Tdap _____/_____/_____

Meningococcal Vaccine Information

For individuals 18 years or older:

I am 18 years of age or older. I have received and reviewed the information provided on the risk of meningococcal disease and the effectiveness and availability of meningococcal vaccine. I understand that meningococcal disease is rare but life-threatening illness. I understand that Maryland law requires an individual enrolled in an institution of higher education in Maryland who resides on campus in student housing shall receive vaccination against

Meningococcal Waiver

I choose to waive the meningococcal vaccine.

_____
_____/_____/_____
Signature of student (parent if student is not 18)

Date _____/_____/_____
_____/_____/_____

meningococcal waiver must be signed by student/parent.

OR **Meningococcal Vaccine**

MCV (Menactra/Menveo)

OR

MPSV (Menommune)

If vaccine has not been received,

Tuberculin Test

Students must have had a PPD or TB blood test within the last two years, unless there is a history of a positive PPD or TB blood test. Please note: A PPD or TB blood test is required regardless of BCG history.

Date read _____/_____/_____
Interpretation_____

History of NEGATIVE TB Test
test

Date of test _____/_____/_____
_____/_____/_____
Test used_____

Date read _____/_____/_____
Interpretation_____

History of POSITIVE TB

Date of test

Test used_____

OTHER IMMUNIZATIONS

Hepatitis B (recommended)
(Quadrivalent
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
_____/_____/_____
Dose 3 _____/_____/_____
_____/_____/_____

Hepatitis A (recommended)
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

Hepatitis A/B
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____
Dose 3 _____/_____/_____

Other
_____
_____

Varicella
History of Disease (Year) _____
OR
Dose 1 _____/_____/_____
Dose 2 _____/_____/_____

HPV
Papillomavirus Vaccine)
Dose 1
Dose 2
Dose 3

MICA
Student Health Services
by Chase Brexton

Health Care Provider (include title):

Practitioners signature	Print last name			Date
Address	City	State	Zip	Phone Number

Meningococcal Vaccine Waiver

If you choose **not** to receive a Meningitis Vaccination, it is mandatory that you sign and return this form by **July 31, 2020** by email at **healthservices@mica.edu** or US mail to:

Student Health Services
Maryland Institute College of Art
1501 West Mt. Royal Avenue
Baltimore, Maryland 21217

If you **have** received a Meningitis Vaccination, please have your physician document this information on Page 6 of the MICA Health History Form.

I have received and reviewed the information provided on the risk of meningococcal disease and the availability of meningococcal vaccine. I understand that meningococcal disease is a rare, but life threatening illness. I understand that Maryland law requires that an individual enrolled in an Institution of higher education in Maryland who resides in on-campus housing shall receive vaccination against meningococcal disease unless they sign a waiver.

I choose to waive receipt of meningococcal vaccine.

Print Student's Name _____

Student's Date of Birth _____

Date _____

Student's Signature (if 18 or older) _____

Parent/Guardian's Signature (if student is under 18) _____