Williams College
Student Health and Wellness
Williamstown, Massachusetts 01267
Tel. (413) 597-2206
Fax (413) 597-2982
Health@Williams.edu

Dear New Students to Williams (including Undergraduate, Graduate and Transfer students),

Health Services would like to welcome you to Williams College. Below is a check list you can use to make sure you have completed all of the health forms. These forms are required to be submitted to the Portal https://williams.medicatconnect.com/ by July 1, 2023. If you have any question about these forms, please email Health@Williams.edu

Form	Instructions	Completed
Physical Form – We will accept any physical completed after 7/1/2022. Please have your healthcare provider complete our physical form or we will accept a physical form printed from your healthcare provider's patient portal (If *you plan to play intercollegiate sports you must use* ***our physical form*** *and it must be within the 6-month period preceding your sport season: August 30 for Fall sports, November 1 for Winter and Spring sports.)*	This form needs to be uploaded to the Portal	
Immunization form – you may use this form or we will accept an immunization form printed from your healthcare provider's patient portal.	This form needs to be uploaded to the Portal	
Immunization part two	Online form, need to enter immunization and dates on the Portal	
Parental Consent Form for students under the age of 18 only	This form needs to be uploaded to the Portal	
Williams College Health and Consent Form	Online form to be completed on the Portal	
Tuberculosis Risk Assessment Form	Online form to be completed on the Portal	
Tuberculosis Risk assessment Physician Follow-up Form. **Only complete this if the Tuberculosis Risk Assessment Form indicated that it was necessary for you to do so.**	This form needs to be uploaded to the Portal	

PHYSICAL EXAMINATION 2023 -2024

Student: _____ Date of Birth:___/___/_____ Date of Exam: ___/___/_____

A PHYSICAL EXAM IS REQUIRED BY ALL STUDENTS ENTERING WILLIAMS COLLEGE, *including all new undergraduate, graduate and transfer students.*

Students are not eligible to participate in any Williams College sports programs, including intramural and club sports, until this form has been completed and submitted to Health Services. The athletic trainer may have access to the physical examination report of students who elect to participate in athletics.

All Varsity and Junior Varsity Athletes must have had a physical **within the 6 month period** preceding their sport season**.**
The following dates indicate the start of the sport season: **Fall – August 30**; **Winter and Spring – November 1**.

HISTORY PLEASE ANSWER ALL QUESTIONS AND PROVIDE ALL PHYSICAL DATA REQUESTED ON THE FORM

	YES	NO
Prior exertional chest pain		
Prior exertional syncope/ near syncope		
Excessive, unexplained shortness of breath or fatigue with exercise		
Prior history of heart murmur of increased blood pressure		
Family history of premature death or mortality from cardiovascular disease in a relative younger than age 50		
Occurrence in family, specifically hypertrophic cardiomyopathy or dilated cardiomyopathy, long QT syndrome or Marfan's syndrome		

SYSTEM	✓ or describe findings		DESCRIBE ABNORMALITY
Heart/Vascular System:			
Blood Pressure (enter value)	_____/_____		
Precordial Auscultation	No murmur, RRR ☐		
Femoral Pulses	Present and Equal ☐		
Marfan's syndrome	No signs/stigmata ☐		
		✓ IF NORMAL	
Skin		☐	
HEENT		☐	
Lungs/Chest		☐	
Breasts		☐	
Abdomen (rectal if indicated)		☐	
Genito-urinary		☐	
Pelvic (if indicated)		☐	
Lymphatic		☐	
Musculoskeletal		☐	
Neurological		☐	
Endocrine		☐	
Psychological		☐	
Unlimited Physical Activity	☐ **Yes** ☐ **No**	←	**DO NOT LEAVE THIS BLANK**

Height _____ft_____in **Weight** _____lbs **BMI**_____

NCAA REQUIRES SICKLE CELL TESTING (HgbAS) trait status (check one): ☐ AS positive ☐ AS negative

Lab work recommended: Hgb/Hct_____ Cholesterol_____ HDL_____ LDL_____ Urine: Glucose_____ Protein_____

CURRENT MAJOR AND CHRONIC PROBLEMS	ACUTE OR MINOR PROBLEMS

IF THE STUDENT IS UNDER CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE ADDITIONAL CLINICAL REPORTS TO ASSIST US IN PROVIDING CONTINUITY OF CARE.

ALLERGIES (medications, insect venom, foods, etc.):_____Type of reaction:_____

CURRENT MEDICATIONS (include vitamins, oral contraceptives, Rx, etc.)_____

Do you have any dietary recommendations? ☐ Yes ☐ No Please specify:_____

Please note any additional recommendation regarding this student:_____

Health Care Provider (Not a relative; Please Print):_____

Address:_____

Phone: (_____)_____ Fax: (_____)_____

Provider's Signature:_____ **Date:**_____

Completed forms should be uploaded to the
Williams College
Ephs Patient Portal
https://williams.medicatconnect.com
by July 1

Student Name: Last _____ First _____ Date of Birth _____

Williams College Immunizations 2023 - 2024 Due by 7/1/2023

This form must be completed and signed by a health care provider, we will also accept a signed Immunization form from your health care provider's Electronic Medical Records

FAILURE TO COMPLY WITH MASSACHUSETTS IMMUNIZATION LAW (see 2nd page) WILL RESULT IN A HOLD ON ACCESS TO YOUR DORM ROOM KEY

Required Vaccines	
MMR	# 1 ___/____/____ #2 ____/____/____ Or attach documented proof of Positive Titer
Measles	# 1 ___/____/____ #2 ____/____/____ Or attach documented proof of Positive Titer
Mumps	# 1 ___/____/____ #2 ____/____/____ Or attach documented proof of Positive Titer
Rubella	# 1 ___/____/____ #2 ____/____/____ Or attach documented proof of Positive Titer
Tdap (Td or Tdap should be given if it has been ≥10 years since Tdap)	____/____/____
Meningococcal ACWY (Not Meningococcal B)	____/____/____ Or Signed Waiver see page 3
Varicella	# 1 ___/____/____ #2 ____/____/____ Or attach documented proof of Positive Titer History of Disease ____/____/____
Hepatitis B	# 1 ___/____/____ #2 ____/____/____ #3 ____/____/____ Or attach documented proof of Positive Titer
Recommended vaccines	
Moderna	#1____/____/____ #2____/____/____ #3___/___/___
Pfizer	#1____/____/____ #2____/____/____ #3___/___/___
Janssen (Johnson and Johnson)	#1 ____/____/____ 2#___/___/___
AstraZeneca	#1____/____/____ #2____/____/____ 3#___/___/___
Meningitis B- Bexsero	#1____/____/____ #2____/____/____
Meningitis B- Trumenba	#1____/____/____ #2____/____/____ #3____/____/____
HPV	# 1 ___/____/____ #2 ____/____/____ #3 ____/____/____
Influenza (there will be a Flu clinic on campus)	____/____/____
Other vaccaines	
Hepatitis A	# 1 ___/____/____ #2 ____/____/____
Pneumococcal Polysacchcaride (PPV)	____/____/____
Polio Primary Series: Oral/Injectable	Most recent Booster ____/____/____
Rabies	# 1 ___/____/____ #2 ____/____/____ #3 ____/____/____
Typhoid	Oral/Injectable ____/____/____
Yellow Fever	____/____/____
Other	
Other	

Health Care Provider (Not a relative; Please print): _____ Date _____

Address: _____

Phone: _____ Fax: _____

Provider's Signature: _____

The immunization provided by your physician should be entered into the Williams College Patient portal http://williams.medicatconnect.com by July 1 and the signed form should be uploaded according to the instructions on the site. If you have questions, call 413-597-2206

version 23-24

Requirements apply to all students including individuals from another country attending or visiting classes or educational programs as part of an academic visitation or exchange program. Requirements apply to all students, even if over 18 years of age.

College (Postsecondary Institutions)**†

Requirements apply to all full-time undergraduate and graduate students under 30 years of age and all full- and part-time health science students. Meningococcal requirements apply to the group specified in the table below.

Tdap	**1 dose;** and history of a DTaP primary series or age-appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td or Tdap should be given if it has been ≥10 years since Tdap
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable; 2 doses of Heplisav-B given on or after 18 years of age are acceptable
MMR	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable. Birth in the U.S. before 1957 acceptable only for non-health science students
Varicella	**2 doses;** first dose must be given on or after the 1st birthday and second dose must be given ≥28 days after first dose; a reliable history of chickenpox* or laboratory evidence of immunity acceptable. Birth in the U.S. before 1980 acceptable only for non-health science students
Meningococcal	**1 dose;** 1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger. The dose of MenACWY vaccine must have been received on or after the student's 16th birthday. Doses received at younger ages do not count towards this requirement. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided by their institution. Meningococcal B vaccine is not required and does not meet this requirement

§ Address questions about enforcement with your legal counsel. School requirements are enforced at the local level.

** The immunization requirements apply to all students who attend any classes or activities on campus, even once. If all instruction and activities are remote and the student will never be on campus in person, the requirements would not apply. Should a student physically return to campus, they would need comply with this requirement

†Medical exemptions (statement from a physician stating that a vaccine is medically contraindicated for a student) must be renewed annually at the start of the school year and religious exemptions (statement from a student, or parent/guardian if the student is <18 years of age, stating that a vaccine is against sincerely held religious beliefs) should be renewed annually at the start of the school year.

*A reliable history of chickenpox includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant, or designee.

WILLIAMS COLLEGE STUDENT HEALTH SERVICES

PARENTAL CONSENT

FOR MEDICAL CARE AND SHARING OF HEALTH INFORMATION

Student's Name: _____

Student's Williams ID #: _____

Student's Date of Birth: _____

As parent/legal guardian of the student indicated above, who has not yet attained the age of 18, I hereby consent to the provision by Student Health Services of such medical care as may be require while the student is at Williams College, including referral to a hospital, emergency facility or other outside health care provider when necessary to provide appropriate treatment. I also consent to the sharing by Student Health Services of health information about the student with (i) such other health care clinicians when necessary to support appropriate services and treatment and (ii) to other departments of the College when necessary to establish the student's eligibility to participate in programs or activities sponsored or organized by the College.

Name of Parent/Guardian:_____

Please Print Name *Relationship to Student*

Parent/Guardian's Signature:_____

Tuberculosis Risk Assessment
Medical Provider Follow-up Form

NAME: Last_____ **First**_____ **Date of Birth**_____/_____/_____

Student:

Please indicate which of these three questions you answered "yes" to on the electronic risk assessment:

- ❑ Have you had close contact with anyone who was sick with tuberculosis (TB)?
- ❑ Were you born in a country other than Australia, Canada, New Zealand, the U.S. or Western Europe?
- ❑ Have you traveled or lived for more than a month in a country other than Australia, Canada, New Zealand, the U.S. or Western Europe?

Health Care Provider:

Please use this form to document the required Tuberculosis testing and follow-up you have provided for this student:

Based on the information provided by the student, a PPD test (Mantoux) within the previous 12 months is required.
Please administer and/or record PPD test results below:

Date Planted:_____	Date Read:_____	Results:_____m of Induration

If PPD is negative, **STOP HERE**.

If PPD is positive, or there is a history of a positive PPD without treatment*, Interferon Gamma Release Assay (IGRA or Tspot) is required.

IGRA or Tspot Date (mm/dd/yyyy):_____	Result: Positive_____ or Negative_____

If IGRA is negative, **STOP HERE**.

Chest X-ray required if IGRA or Tspot is positive

Chest X-Ray Date (mm/dd/yyyy):_____	Results: Normal_____ or Abnormal_____

If Chest X-Ray is normal, **STOP HERE**.

Copy of Chest X-Ray Report is required if result is abnormal.

'* If you have been treated for a positive PPD or IGRA/Tspot, no further testing is required. Please document below, including dates of treatment.

_____

_____

_____

Name of Health Care Provider (please print):_____

Signature of Health Care Provider:_____

Signature ***Date***