

Deadlines:

June 15: Fall Admission, Undergraduate, Graduate, and Ada Comstock

January 19: Spring Admission

HEALTH FORM PACKET: REQUIRED OF ALL STUDENTS

- ▶ All pages must be completed with name, date of birth, and Smith ID number, and signed as indicated.
- ▶ Failure to submit this information by the deadline will result in a hold on student accounts.
- ▶ Please complete this checklist and all required documentation.

 Page 1: Student information, medical insurance, consent, and financial responsibility.

- Emergency contact must be a parent/guardian for students under age 18. One U.S. contact is preferred.
- Health insurance coverage is required for all students, as per Massachusetts law.
- Smith College offers a plan that is specifically designed to meet student needs. Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
- Students who waive the Student Health Insurance Plan must upload copies of both sides of their insurance cards.

 Page 2: Immunizations: Proof of required immunizations or immunity by blood test.

- Upload the enclosed form, completed and signed by your physician, OR a copy of your immunization record.
- Submit copies of blood test report(s) results if titers are being submitted.
- Questions about vaccine waivers should be directed to healthservices@smith.edu.

 Page 3: Tuberculosis Risk Screening: Date of screening must be no earlier than May 1, 2026.

- Tuberculosis screening questions must be completed and signed by the student or legally responsible parent/guardian.
- Testing is needed only if a student answers YES to any of the items on the screening questionnaire.
- No further testing or imaging is needed if provider documentation of completed latent TB treatment is submitted.

 Page 4: Tuberculosis Medical Evaluation: Complete only if you answer YES to questions on page 3. Date of testing must be no earlier than May 1, 2026.

- Medical provider (MD, DO, NP, PA) review and signature required if you answer YES to questions on page 3.
- Submit copies of written blood test report(s) and/or chest X-ray report(s), if applicable.

 Page 5: Medical Examination Form.

- Submit a copy of your recent physical exam: Date of exam must be within 23 months prior to matriculation.
- Your health care provider must review AND sign the medical examination form unless notes from a physical are submitted.

 Page 6: NCAA Pre-Participation Exam: Complete only if you intend to play an NCAA sport.

- Complete this form if you intend to play a team sport. Not required for club/extracurricular sports.
- Date of exam must be within 6 months prior to matriculation and before arrival on campus.
- EKG and referral to cardiology AND a copy of these records are required for any significant history and/or findings.
- Provide provider certification of negative sickle cell screening or a copy of a negative blood test result, as required by NCAA.
- Completed forms must also be emailed to athletictraining@smith.edu.

▶ **UPLOAD YOUR COMPLETED PACKET TO OUR CONFIDENTIAL PATIENT PORTAL.**<https://smith.medicatconnect.com>

- Online instructions and additional forms are available at smith.edu/health.
- You may mail or fax records to 413-585-4639 if needed.
- *Do not email forms, health records, or test results. They will not be accepted.*

Failure to submit all required information by the deadline will result in a HOLD on student accounts. Clearance for registration, classes, and other activities is not granted until all required information is received.

QUESTIONS? Please contact healthservices@smith.edu.**See website for information about health forms, insurance, services, and resources: smith.edu/health.**

UPLOAD all information.

We do not accept emailed information due to confidentiality concerns.

Keep a copy of all information sent.

Last Name _____ **First Name** _____ **Date of Birth** ____ / ____ / ____ **Smith ID# 99** _____
MM DD YYYY

STUDENT INFORMATION

Chosen Name _____ Pronouns _____ Assigned Sex at Birth _____

Street Address _____

City/State/Region/Country/ZIP Code _____

Telephone _____ Email _____

Country of Birth _____ Undergraduate Ada Graduate Transfer Class of: _____

EMERGENCY CONTACT

Name of individual(s) over age 18 to be contacted in an emergency and who is able to make medical treatment decisions. *If the student is younger than age 18, the legally responsible parent(s) or guardian must be listed first. Please include a U.S. contact.*

Name _____ Relationship to Student _____

Telephone 1 _____ Telephone 2 _____ Email _____

Name _____ Relationship to Student _____

Telephone 1 _____ Telephone 2 _____ Email _____

MEDICAL INSURANCE – All students are automatically enrolled in the Student Health Insurance Plan.

- Health insurance coverage is required for all students per Massachusetts law. The Student Health Insurance Plan is available and is specifically designed to meet the needs of students. It is accepted by most off-campus providers in our local area without a referral, and covers vaccines and laboratory and radiology services. Deductibles and co-pays do apply.
- Contact Student Financial Services at 413-585-2530 or sfs@smith.edu with questions about waiving/purchasing health insurance. Additional information is available at smith.edu/student-health-insurance.
- Students who waive the Student Health Insurance Plan should determine if LabCorp (on-site reference lab) is in-network and whether immunizations provided by the Schacht Center will be covered.

Students waiving the Student Health Insurance Plan MUST submit a copy of both sides of their insurance cards.

Students are responsible for any charges or services not covered by insurance.

FINANCIAL RESPONSIBILITY and CONSENT: Undergraduate, Graduate, and Ada Comstock Students only

I hereby give permission to the Schacht Center for Health and Wellness to provide me (or the aforementioned student under 18 years of age) with general, non-surgical medical treatment and diagnosis, including, but not limited to, immunizations or such other health care as the Schacht Center for Health and Wellness shall determine to be medically necessary or desirable. Further, in the event of a medical emergency when my emergency contact(s) identified above cannot be reached, I hereby give permission for the director of Smith College Health Services, or designee, to make treatment decisions for me (or the aforementioned student under 18 years of age), including, but not limited to, urgent or emergency care and hospitalization, if deemed necessary at the discretion of the Schacht Center for Health and Wellness in order to avoid delay which might jeopardize life and/or recovery. Finally, I understand that charges for any services at the Schacht Center for Health and Wellness that are not covered by medical insurance will be billed to my account, for that I accept full financial responsibility.

| | |
|--|-------------|
| Signature of student | Date |
| Required of all students | |
| Signature of legally responsible parent or guardian | Date |
| Required of all students under 18 years of age | |

This page is to be completed by the student/family. Upload this completed page to the patient portal at smith.edu/health.

Do not give this page to your doctor.

Last Name _____ First Name _____ Date of Birth ____ / ____ / ____ Smith ID# 99 _____
MM DD YYYY

IMMUNIZATIONS

- ALL students must comply with Massachusetts School Immunization Requirements.

Failure to meet all requirements by the deadline will result in a hold on all student accounts.

Most U.S. retail pharmacies and walk-in or urgent care clinics can provide and administer vaccines.

| REQUIRED IMMUNIZATIONS: Include dates of administration in MM/DD/YYYY format | Date Dose 1 MM/DD/YYYY | Date Dose 2 MM/DD/YYYY | Date Dose 3 MM/DD/YYYY | Date Dose 4 MM/DD/YYYY | TITER: Date and Result <i>Include copy of results if titers are performed</i> |
|--|---------------------------|---------------------------|---------------------------|---------------------------|--|
| Tetanus-Diphtheria-Pertussis Completed childhood primary series (date of final dose of DTP/DaP) | | | | | N/A |
| Tdap (Adacel or Boostrix) 1 dose within 10 years | | | | | N/A |
| Hepatitis B 3 doses (0, 1 month, 4-6 months apart) or 2 doses of Heplisav after age 18 (Specify if Heplisav-B) or positive titer (lab report required) | | | | | |
| MMR: Measles, Mumps, Rubella MMRV: Measles, Mumps, Rubella, Varicella 2 doses of MMR or MMRV 1st dose after 12 months of age 2nd dose at least 28 days after dose 1 or positive titers for each (lab report required) (may waive for US birth before 1957) | | | | | |
| Varicella (Chicken Pox) 2 doses 1st dose after 12 months of age 2nd dose at least 28 days after dose 1 or positive titer (lab report required) or provider-verified medical documentation of disease with date (may waive for US birth before 1980) | | | | | |
| Quadrivalent Meningitis (Students age 21 or younger) (MenACWY/MCV4/Menactra/Menveo) 1 dose on or after age 16 | | | | | N/A |
| HIGHLY RECOMMENDED IMMUNIZATIONS | | | | | |
| COVID-19 Please note the vaccine type in the corresponding date box. | | | (booster) | (booster) | N/A |
| Hepatitis A | | | | | N/A |
| Human Papillomavirus | | | | | N/A |
| Polio primary series completed before age 4 | | | | | N/A |
| Meningitis B (Students under age 23) <input type="checkbox"/> Bexsero <input type="checkbox"/> Trumenba | | | | | N/A |
| Most recent Flu Vaccine | | | | | N/A |
| OTHER IMMUNIZATIONS | | | | | |
| Japanese Encephalitis (Ixiaro) | | | | | N/A |
| Rabies | | | | | N/A |
| Typhoid (injectable) | | | | | N/A |
| Typhoid (oral) | | | | | N/A |
| Yellow Fever | | | | | N/A |

You must submit an official copy of your immunization records OR your physician must complete AND sign this form.

I HAVE REVIEWED THIS HISTORY WITH THE STUDENT AND ATTEST TO ITS ACCURACY.

| Provider Name | M.D./D.O. N.P./P.A. | Signature | Date |
|---------------|------------------------|---------------------|------|
| Address | City/Town | State/County/Region | |
| Country | Telephone | Fax | |

Upload this completed page to the patient portal at smith.edu/health.

Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

Last Name _____ First Name _____ Date of Birth / / _____ Smith ID# 99 _____
MM DD YYYY

TUBERCULOSIS (TB) RISK SCREENING (Required for ALL Students) Complete within 3 months prior to matriculation.

If the answer to any question below is **YES**, the Tuberculosis (TB) Medical Evaluation Form on page 4 must be completed.

- | | | Date(s) |
|---|--|----------------|
| 1. Have you ever had a positive tuberculosis (TB) skin test? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 2. Have you ever had close contact with anyone who was sick with TB? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 3. Have you ever been a resident, volunteer, and/or employee of a high-risk congregate setting (i.e., correctional facility, long-term care, or homeless shelter) or a health care worker who served clients who are at increased risk for active TB? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 4. Were you born in one of the countries listed below? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 5. Within the past five years, have you lived in or traveled to any of the countries below for more than two weeks? | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| 6. Please CIRCLE the country in which you were born AND any of the countries you lived in within the past five years, or traveled to for more than two weeks. | | |

| | | | | |
|----------------------------------|--------------------------------|---|--------------------------|------------------------------------|
| Afghanistan | Colombia | Indonesia | Mozambique | South Africa |
| Algeria | Comoros | Iraq | Myanmar | South Sudan |
| Angola | Congo | Kazakhstan | Namibia | Sri Lanka |
| Anguilla | Congo (Democratic Republic of) | Kenya | Nauru | Sudan |
| Argentina | Cote d'Ivoire | Kiribati | Nepal | Suriname |
| Armenia | Djibouti | Korea (Democratic People's Republic of) | Nicaragua | Tajikistan |
| Azerbaijan | Dominican Republic | Korea (Republic of) | Niger | Tanzania (United Republic of) |
| Bangladesh | Ecuador | Kyrgyzstan | Nigeria | Thailand |
| Belarus | El Salvador | Lao People's Democratic Republic | Niue | Timor-Leste |
| Belize | Equatorial Guinea | Lesotho | Northern Mariana Islands | Togo |
| Benin | Eritrea | Liberia | Pakistan | Tunisia |
| Bhutan | Eswatini | Libya | Palau | Turkmenistan |
| Bolivia (Plurinational State of) | Ethiopia | Lithuania | Panama | Tuvalu |
| Bosnia and Herzegovina | Fiji | Madagascar | Papua New Guinea | Uganda |
| Botswana | Gabon | Malawi | Paraguay | Ukraine |
| Brazil | Gambia | Malaysia | Peru | Uruguay |
| Brunei Darussalam | Georgia | Maldives | Philippines | Uzbekistan |
| Burkina Faso | Ghana | Mali | Qatar | Vanuatu |
| Burundi | Greenland | Marshall Islands | Romania | Venezuela (Bolivarian Republic of) |
| Cabo Verde | Guam | Mauritania | Russian Federation | Viet Nam |
| Cambodia | Guatemala | Mexico | Rwanda | Yemen |
| Cameroon | Guinea | Micronesia (Federated States of) | Sao Tome and Principe | Zambia |
| Central African Republic | Guinea-Bissau | Moldova (Republic of) | Senegal | Zimbabwe |
| Chad | Guyana | Mongolia | Sierra Leone | |
| China | Haiti | Morocco | Singapore | |
| China, Hong Kong SAR | Honduras | | Solomon Islands | |
| China, Macao SAR | India | | Somalia | |

Source: https://www.acha.org/wp-content/uploads/ACHA_Tuberculosis_Risk_Assessment_and_Management_April_2025.pdf

If the answer to all of the above questions is **NO**, no further testing is required.

If the answer to ANY of the questions above is YES:

- The Tuberculosis (TB) Medical Evaluation (page 4) must be completed and signed by a medical provider.
- You are required to have an Interferon Gamma Release Assay (IGRA blood test) or a Tuberculin Skin Test/PPD (TST) **if IGRA is not available**. This must be dated within 3 months of matriculation.

If a Tuberculin Skin Test is completed, an IGRA blood test will be required upon arrival.

- A CHEST X-RAY is REQUIRED before arrival on campus for any positive IGRA blood test or skin tests.

| | |
|--|-------------|
| Signature of student | Date |
| <i>Required of all students</i> | |
| Signature of legally responsible parent or guardian | Date |
| <i>Required of all students under 18 years of age</i> | |

This page is to be completed by the student/family. Upload this completed page to the patient portal at smith.edu/health. Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

Last Name _____ First Name _____ Date of Birth ____ / ____ / ____ Smith ID# 99 _____
MM DD YYYY

TUBERCULOSIS (TB) MEDICAL EVALUATION

Please Note: Failure to provide complete documentation will result in the inability to travel to campus, register in classes, or participate in college-related events. Any person currently being treated for active TB will be required to provide documentation of treatment and meet with a medical provider upon arrival. **Any person being treated for active TB without documentation will not be allowed on campus.**

1. Does student have past or current diagnosis, signs, or symptoms of active tuberculosis disease? NO YES

Students with a history or current diagnosis of active TB or who were treated for latent TB must provide the following:

- Documentation from a tuberculosis specialist indicating that the student is **no longer infectious** and including treatment details:
 - Name(s) of medication, dose, frequency taken
 - Duration of treatment, start date(s) of treatment, date(s) treatment completed
 - Copies of all sputum results and chest X-rays

No further testing or imaging is needed if the student has the above treatment verification documentation.

2. Interferon Gamma Release Assay (IGRA): Required if any YES answers on page 3 or for any positive skin test.

Type of Test: TSpot.TB test OR QFT-GIT **Must be dated no earlier than May 1, 2026.**
 (If Indeterminant, repeat IGRA testing will be required.)

Please attach lab results.

- If IGRA is negative, no further action is required.
- If IGRA is not available, complete section 3 below.
- If IGRA is positive, a chest X-ray is required. Complete section 4 below.

3. Tuberculin Skin Test/PPD (TST): Only complete if IGRA testing is not available. Must be dated no earlier than May 1, 2026.

Please note: An IGRA blood test will be required upon arrival. Lab testing is billed to insurance.

Date given ____/____/____ Date read ____/____/____ **Result:** _____ mm of induration, transverse diameter
MM DD YYYY MM DD YYYY

Interpretation: Negative Positive (Chest X-ray required)

Interpretation of Tuberculin Skin Test guidelines: Interpretation is based on mm of induration and risk factors below.

| Risk Factor | Result is considered POSITIVE if induration is equal or greater than: |
|---|--|
| Close contact with an individual with infectious tuberculosis | 5 mm or more |
| Born in a country that has a high rate of tuberculosis | 10 mm or more |
| Traveled or lived for two weeks or more in a country that has a high rate of tuberculosis | 10 mm or more |
| No risk factor (Test not recommended) | 15 mm or more |

4. Chest X-ray: Required if IGRA is positive OR if skin test is positive. Must be dated no earlier than May 1, 2026.

Date of chest X-ray ____/____/____
MM DD YYYY

Result: Normal Abnormal

If ABNORMAL, consultation with a medical provider is needed for medical clearance prior to arriving on campus.

Attach chest X-ray report

Attach consultation note

I HAVE REVIEWED THIS FORM AND ATTEST THAT THE STUDENT IS AT LOW TO NO RISK FOR TUBERCULOSIS EXCEPT AS INDICATED ABOVE.

| | | | |
|----------------------|--------------------------------|---------------------|-------------|
| Provider Name | M.D./D.O. N.P./P.A. | Signature | Date |
| Address | City/Town | State/County/Region | |
| Country | Telephone | Fax | |

Upload this completed page to the patient portal at smith.edu/health.

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Last Name _____ First Name _____ Date of Birth / / Smith ID# 99 _____
MM DD YYYY

MEDICAL EXAMINATION

Date of Exam _____

Exam must be performed no earlier than August 1, 2024.

To be completed and signed by the health care provider. No portion of this form may be completed by a student's family member.

HEALTH HISTORY: No known significant medical history

Check and provide dates and details below if there is a significant medical history:

| | | | | | | |
|--|--|---|---|---|---|---------------------------------------|
| <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Surgery | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Abnormal Pap Smear | <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Alcohol or Drug Abuse | <input type="checkbox"/> Asthma Bronchitis/Pneumonia/Lungs | <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Blood Clot or Phlebitis | <input type="checkbox"/> Bowel Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ears or Hearing | <input type="checkbox"/> Eyes or Vision | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Emotional or Mood Changes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Head Injury or Concussion | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Immune System | <input type="checkbox"/> Kidney Stones or Disease | <input type="checkbox"/> Learning Differences | <input type="checkbox"/> Liver or Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Metabolic/Endocrine | <input type="checkbox"/> Migraine or Other Headaches | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Orthopedic or Bones | <input type="checkbox"/> Reproductive System/Menstruation | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Weight Change | <input type="checkbox"/> Fainting or Loss of Consciousness | <input type="checkbox"/> Urinary Tract Infections | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: |

PHYSICAL EXAM: Height _____ Weight _____ BMI _____
 BP _____ HR _____ RR _____

| | Normal | Description | N/A |
|----------------------------|--------|-------------|-----|
| General constitutional | | | |
| Head Ears Eyes Neck Throat | | | |
| Heart / Cardiovascular | | | |
| Respiratory / Lungs | | | |
| Gastrointestinal | | | |
| Genitourinary | | | |
| Reproductive | | | |
| Neurological | | | |
| Immune / Lymphatic | | | |
| Hematologic / Blood | | | |
| Metabolic / Endocrine | | | |
| Psychiatric | | | |

ALLERGIES: No Known Allergies Medications
 Food Insect Bites *If so, list below and describe reaction.*

| |
|--|
| |
| |
| |

MEDICATION: Does the student use any medications (Including inhalers, hormones, or contraception)
 Yes No

If yes: List names of medication, dose, and reason for use.

| | | |
|--|--|--|
| | | |
| | | |
| | | |

FAMILY HISTORY: Has anyone in immediate family had:

- Sudden death before age 50 Heart Attack
- Blood Clot Heart Disease High Blood Pressure
- Diabetes Cancer Asthma Lung Disease
- Kidney Stone

ATHLETICS EXAMINATION:

Is student participating in an intercollegiate sport?
 Yes No

If yes: Complete the NCAA Athletic Pre-Participation Physical Exam (page 6)

DESCRIBE ABOVE:

| | | | |
|----------------------|--------------------------------|---------------------|-------------|
| Provider Name | M.D./D.O. N.P./P.A. | Signature | Date |
| Address | City/Town | State/County/Region | |
| Country | Telephone | Fax | |

Upload this completed page to the patient portal at smith.edu/health.

Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.

Last Name _____ First Name _____ Date of Birth ____ / ____ / ____ Smith ID# 99 _____
Exam must be performed within 6 months of matriculation. MM DD YYYY

Date of Exam _____

NCAA ATHLETIC PRE-PARTICIPATION PHYSICAL EXAM
THIS FORM IS REQUIRED FOR STUDENTS PLANNING TO PLAY ON AN NCAA TEAM

| Personal Health History—Have you ever had: | No/Never | If yes, provide description and dates if known. |
|---|----------|--|
| Head injury/concussion | | |
| Significant injury or fracture | | |
| Asthma or breathing problem Do you have an inhaler? | | |
| Unexplained seizure When? | | |
| Admission to hospital For what? | | |
| Concern for body weight and/or size | | |
| Age of first menstrual period | | |
| Missed more than three consecutive periods in the past 2 years? | | |
| Do you vape or smoke? What? | | |
| Cardiac History | | If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS |
| Chest pain, fainting, dizziness with exercise | | |
| Excessive breathlessness | | |
| Irregular heartbeat/arrhythmia/palpitations | | |
| Has anyone in your immediate biological family had: | | If yes, provide description and dates if known. EKG AND/OR CARDIAC CONSULT REQUIRED FOR SIGNIFICANT FINDINGS |
| Sudden or unexplained death before age 50, seizure, or drowning | | |
| Heart problem/ heart attack | | |
| Diabetes, asthma, cancer or seizures | | |
| High blood pressure or blood clots | | |

| Physical Exam | Normal / Unremarkable | Findings: |
|---|-----------------------|-----------|
| Appearance (Assess for Marfan Stigmata) | | |
| Head/Ears/Eyes/Nose/Throat | | |
| Lymph Nodes | | |
| Cardiac Assessment: Performed seated, supine, squatting, & with Valsalva. Assess for murmurs. | | |
| Pulses (Femoral /Radial/Pedal) | | |
| Lungs | | |
| Abdomen | | |
| Skin (MRSA/HSV/Tinea) | | |
| Neurologic: including reflexes & strength | | |
| Psychiatric | | |
| Musculoskeletal: Neck/ Back/ Spine | | |
| Musculoskeletal: Extremities | | |
| Musculoskeletal: Joints | | |
| Vision: R L Corrected? | | |

All participating student-athletes are required to provide confirmation of sickle cell trait status, either through: 1) existing documentation from birth, or 2) recent screening. If students are unable to access testing prior to arrival, labs can be completed at the Schacht Center. Lab fees and deductibles apply.

- I attest that student has negative sickle cell screening. Or a copy of the student's negative sickle cell testing is attached. (Provide copy of results).

Please attach further notes as desired.

CLEARED FOR ALL ATHLETICS WITHOUT RESTRICTION

- Not cleared for athletics: Advise further evaluation for _____
 EKG performed and attached. Referred to Cardiology: Name of Provider _____ Date of Appointment _____
 Cardiology clearance letter attached, if applicable.

I HAVE EXAMINED THE ABOVE-NAMED STUDENT. MY FINDINGS AND RECOMMENDATIONS ARE AS INDICATED ABOVE.

| Provider Name | M.D./ D.O. N.P./ P.A. | Signature | Date |
|---------------|--------------------------|-----------|---------------------|
| Address | City/Town | | State/County/Region |
| Country | Telephone | | Fax |

Upload this completed page to the patient portal at smith.edu/health AND email to athletictraining@smith.edu.
Your health care provider's office may fax this form, test results, and a copy of your immunization records to 413-585-4639.