



HEALTH FACE SHEET

PH: 508-830-5048
Fax: 508-830-6468

Mailing: Medical Department, Mass Maritime Academy,
101 Academy Drive Buzzards Bay, MA 02532

Name _____
Last First Middle

Address: _____
Street City State Zip

Birth date: ___/___/___ Age: ___ Gender: _____

E-mail (*non-MMA*) _____ Cell (____) _____

EMERGENCY CONTACT INFORMATION

Name _____
Last First Middle

Relationship _____ Home (____) _____ Cell (____) _____

INTENDED MAJOR/FIELD OF STUDY: _____

HEALTH INSURANCE: Name of Policy Holder: _____ DOB: _____

I plan on purchasing insurance through MMA. Yes

**Please attach a copy of the front AND back of your insurance cards.*

MUST COMPLETE WITH YOUR PCP:

Yes	No	Please check yes/no for each below.	Yes	No	Please check yes/no for each below.
		Asthma/Lung Disease			Any Hospital Admission/Surgeries
		Heart Problems			Any Chronic Medical Conditions
		Heart Murmur/Palpitations			Hernia
		Chest Pain With Exercise			Orthopedic Injury Requiring Surgery
		Family History of Sudden Cardiac Death or Collapse			Has your physical activity been restricted in the past five years
		Seizures or Epilepsy			ADD/ADHD
		Sleep Disorder/Sleepwalking			Psychiatric or Mental Health Disorders
		Dizziness/Fainting Spells			Anxiety/Depression
		Diabetes			Alcohol or Drug Abuse or Dependency
		Impairment of Vision/Color Vision			Eating Disorder
		Impairment of Hearing			Suicidal Thoughts or Suicide Attempt
		Head Injury/Concussion			Admission to a Psychiatric Hospital or Program
Further Information on Above:					
Surgical Dates and Outcomes:					
Other Medical Information:					
Medications					
Allergies					

VISUAL ACUITY: Required for: MARINE TRANSPORTATION AND MARINE ENGINEERING MAJORS.

UNCORRECTED VISION: Right _____ Left _____ CORRECTED VISION: Right _____ Left _____

Field of Vision: (must be 180 degrees or greater) Normal Abnormal

COLOR VISION: (choose one) Required for: MARINE TRANSPORTATION AND MARINE ENGINEERING MAJORS.

Ishihara (14 plate) Pass Fail Number of Errors: _____

Farnsworth Lantern Pass Fail

NAME _____

DOB _____

NAME _____

DOB _____

PHYSICAL EXAM FORM

Check each item in proper column.	NORMAL	ABNORMAL	GIVE DETAILS OF ABNORMALITY
1. Head/Face/Neck/Scalp			
2. Eyes / Pupils / EOM			
3. Mouth / Throat			
4. Ears / Drums			
5. Lungs			
6. Heart			
7. Abdomen/Bowel-Include Hernia			
8. Vascular System			
9. Endocrine System –Thyroid/Diabetes			
10. GU System			
11. Upper Extremities-strength/range of motion			
12. Lower Extremities-strength/range of motion			
13. Feet			
14. Spine, Other Muscular-Skeletal			
15. Skin and Lymphatics			
16. Neurologic			
HEIGHT:	WEIGHT:	BMI:	BP: P:

HEARING: NORMAL ABNORMAL

MANDATORY PPD: Date Planted: _____ Date Read: _____ Results: _____

Based on this exam would you endorse participation in all physical activity including: climbing steep or vertical ladders, maintaining balance on a moving ship, pulling a heavy fire hose, lifting heavy objects, stepping over a 24” obstacle and/or opening and closing heavy doors. It is the professional opinion of the undersigned provider that this applicant will have the physical and emotional ability to meet the rigorous demands of Massachusetts Maritime Academy including *Sea Term and is medically stable to participate in the physical activity required by **MMA Orientation and Regimental Duties:

Yes No

Name of Examining Physician: _____ Date _____

Physician’s Signature: _____

**Sea Time on the KENNEDY is physically demanding and is mandatory for licensed track majors.. During the experience cadets will rotate through class and laboratory training at sea; take part in ship operations, including deck/engine watches, maintenance and emergency drills while living and sleeping in close quarters.
**MMA Orientation and Regimental Duties require physical strength and endurance training including running, marching, swimming, intramurals and calisthenics.*



Please provide proof of **ALL REQUIRED** immunizations listed below:

- **Hepatitis A Vaccine:** Two doses required to complete the series. At least one dose must be given prior to attending MMA.
- **Hepatitis B Vaccine:** Completion of the three dose series.
- **Mantoux (PPD) Test:** Tuberculosis skin test with **RESULTS** noted. Must be within **ONE** year of starting at MMA. (If you are not able to receive the test or you had a BCG vaccine you may have an IGRA blood test as an alternative.)
- **Meningococcal Vaccine:** One dose for all residential students given within the last 5 years. **(If the first dose was given before age 16 a booster dose is required.)**
- **MMR Vaccine:** Measles, Mumps and Rubella - two doses or proof of immunity by a blood test.
- **Polio Vaccine:** Primary series and booster dose.
- **Tdap Vaccine:** Tetanus, Diphtheria and Acellular Pertussis - one dose required within the last 10 years.
- **Varicella Vaccine:** Chicken Pox - two doses or documentation of having had the disease or proof of immunity by a blood test.
- **Meningitis B Vaccine:** Recommended not required. First dose before Orientation. Completion of series per protocol.
- **HPV:** Recommended not required.

MMA Health Services
101 Academy Drive Buzzards Bay, MA 02532

PH: 508-830-5048
FAX: 508-830-6468

Email: jkaechele@maritime.edu, kspelman@maritime.edu, rmorrissey@maritime.edu, ksmith@maritime.edu



Instructions for Completing Your On-line Student Health Forms

- Once you receive your PORTAL GUARD Username and Password you are able to begin.
- From the MMA homepage click on STUDENT SERVICES and then HEALTH SERVICES.
- Click on the red words HEALTH PORTAL.
- Using your Portal Guard Username and Password, sign into your ONLINE STUDENT HEALTH PORTAL.
- You have TWO sections to complete – MEDICAL HISTORY and IMMUNIZATIONS
- Under FORMS you will be able to enter your MEDICAL HISTORY and sign our Privacy Policy and Consents. EVERY question needs a response or your information will not be saved. When complete click “SUBMIT”. It may take several seconds for the process to be completed.
- FAILURE TO DISCLOSE MEDICAL HISTORY OR CURRENT MEDICAL CONDITION(S) IS AN HONOR CODE VIOLATION!
- Click on IMMUNIZATIONS to enter the dates you received your required vaccinations. When all your immunizations are entered click “SUBMIT”. You may VIEW HISTORY to see a list of immunizations before you update them or to PRINT a record of your immunizations at any time.
- A copy of your immunizations from your DOCTOR’S OFFICE must be sent to Health Services so we can verify the information you entered.
- You will NOT BE CLEARED TO PARTICIPATE in Orientation until all information is submitted.
- If you have any special medical concerns that have not been addressed please call us as soon as possible.

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