Regis College
Center for Health and Wellness

Dear Incoming Regis Student:

The Regis College Center for Health and Wellness would like to welcome you to Regis.

Massachusetts State Law requires all incoming undergraduate students to provide proof of required immunizations and medical insurance information. In addition, Regis College requires that students have a physical examination, within the past 12 months, **prior to arrival on campus. You must complete and upload all required medical documentation to CastleBranch, an online record management system.** Please refer to pages 2 and 3 for step-by-step instructions. ***Regis athletes*** must complete this process ***in addition to*** the athletic department requirements.

Due Dates:
All health records must be uploaded to CastleBranch by:
→ ***Monday, July 15th, 2024, for fall enrollment***
→ ***Thursday, January 2nd, 2025 for spring enrollment***

You must provide all required health records, including vaccination records, by the due date. Failure to comply with that deadline could result in consequences including removing you from current courses, restricting your access to Moodle, and/or preventing you from registering for future courses. You are responsible for complying with this deadline ***without exception***.

Your health information is confidential and protected by state and federal laws. The information you submit is maintained by the Regis College Center for Health and Wellness in the strictest confidence. Privacy regulations prevent Regis College from releasing or discussing any health information without your written consent, except when there is imminent danger to you or to others, or where permitted by law.

If you have indicated in your health forms that you have ***a medical condition, chronic illness or concerning allergy***, we encourage you to contact the Regis College Center for Health and Wellness at 781-768-7290 to schedule a ***free consultation with one of our health care providers*** to discuss how we may be helpful.

All enrolled Regis College students who study on the Weston Campus are welcome to utilize our ***confidential counseling center*** by calling the Center of Health and Wellness to schedule an appointment. Students are offered twelve free sessions of counseling each academic year.

For students seeking accommodations, (physical, psychological or learning): please contact the Office of Accessibility Services by phone at 781-768-7384 or email: accessibility@regiscollege.edu.

If you have any questions or concerns, please call the Regis College Center for Health and Wellness at (781) 768-7290.

Sincerely,

Tammi Magazzu, RN, WHNP-BC
Associate Dean and Medical Director
Regis College Center for Health and Wellness

Regis College
Center for Health and Wellness

How to use CastleBranch

Setting up your CastleBranch account:

1. Go to CastleBranch.com
2. Select: *Place an order* (top right)
3. Enter Package Code: *EO10 (letters E and O, and numerals 1 and 0)*
4. Accept the Terms and Conditions of Use and select *Continue*
5. The Personal Identification Number (PIN) is the Regis student ID number
6. Enter student's *Regis email address* (which will then become the *myCB* username) along with the required personal information to complete the order.

Log into CastleBranch and download the required forms for printing:

Regis College Health Forms and Instructions Packet (16 pages in total) can be downloaded from Requirement #1 of the To Do List.

Uploading required documentation:

The most effective way to upload a document to CastleBranch is to scan it and save it as a PDF or take a clear photo and upload the PDF or photo to the requirement. ***Please note:*** all uploads must be **clear and legible, and meet the requirements or they will be rejected**.

1. **Regis Health Forms and Instructions Packet:** Download and print the entire Regis Health Forms and Instructions Packet.

2. **Demographic Form:** Please complete and upload ***page 4*** of the Health Forms Packet.

3. **Health History Form:** Please complete and upload ***page 5*** of the Health Forms Packet.

4. **Health Insurance and Consents Form:** Please complete and upload ***page 6*** of the Health Forms Packet. ***In addition to this form, please include a copy of the front and back of the student's medical insurance card.*** *Completed page 6 and a copy of the front and back of the card must be scanned and uploaded together as one document.*

5. **Physical Exam:** Please complete and upload ***page 7*** of the Health Forms Packet. The physical exam must be within 1 year and signed by a health care provider. The Regis physical exam form from the packet or a pre-printed and signed document from a health care provider may be used.

Immunizations (requirements 6 -10): The immunization form (***page 8*** of the Health Forms Packet) or a pre-printed form from a health care provider may be used. If the Regis immunization form is used, it must be signed by a health care provider. If a provider's pre-printed form is used, the student's name, date of birth and the health care provider's name must appear on the document. ***Important:*** *If the immunization record has multiple pages, please upload the entire immunization document for each vaccine requirement listed below.*

6. **MMR (Measles (Rubeola), Mumps, Rubella):**

7. **Varicella (Chicken Pox):**

8. **Hepatitis B:**

9. **Tdap (Tetanus, Diphtheria, Pertussis):**

10. **Meningococcal Vaccination:** Please refer to ***page 12*** of the Health Forms Packet**.**

11. **Tuberculosis (TB) Questionnaire and Testing Forms:** Please refer to ***pages 9, 10 and 11*** of the Health Forms Packet.

ADDITIONAL INFORMATION

- Once all documents have been uploaded, the status for each line item on the To Do List in CastleBranch will be shown as, ***PENDING REVIEW***.
- CastleBranch personnel will review each line item to ensure that the appropriate information has been uploaded.
- If the uploaded documents ***meet the requirements***, the status for the line item on the To Do List in CastleBranch will be changed from ***PENDING REVIEW*** to ***COMPLETE***.
- If the uploaded documents ***do not meet the requirements,*** the status for the line item on the To Do List in CastleBranch will be changed from ***PENDING REVIEW*** to ***REJECTED***. The reason for the rejection can be found under the word ***REJECTED.***
- To ***upload corrected information*** for any line item, a student ***must re-upload ALL pages for that particular CastleBranch requirement***. For example, if a student did not submit a front and back copy of a health insurance card along with page 6, the requirement will be rejected. A student must upload Page 6 ***AND*** a copy of the front and back of the medical insurance card again.
- For questions, please contact Edward Hand, Regis College Center for Health and Wellness Compliance Coordinator at 781-768-7290 or email him at health.services@regiscollege.edu.
- For CastleBranch account support, contact the CastleBranch service desk directly at 888-723-4263.

DEMOGRAPHIC FORM

Name: _____ Date of Birth: _____/_____/_____
Last First MI Month Day Year

Sex assigned at birth: _____ Gender Identity: _____

Permanent Address: _____ _____ _____ _____ _____
Street City State Zip Code Country

Birthplace (country): _____

Home Telephone: (_____) _____ Student's Cell: (_____) _____

Regis Student's ID#: _____ Resident _____ Commuter_____

Regis Email: _____ Regis Athlete: No ___ Yes ___ Sport:_____

Date entering Regis: _____ Expected Date of Graduation: _____

Nursing or Health Science student: No____ Yes___

Parent/Legal Guardian #1

Name: _____

Relationship: _____

Home phone number: (_____) _____

Cell Phone: (_____) _____

Parent/Legal Guardian #2

Name: _____

Relationship: _____

Home phone number: (_____) _____

Cell Phone: (_____) _____

PRIMARY EMERGENCY CONTACT (1st person to call):

Name: _____

Address: _____

Daytime phone: (_____) _____

Evening phone: (_____) _____

Relationship to student: _____

ALTERNATE EMERGENCY CONTACT:

Name: _____

Address: _____

Daytime phone: (_____) _____

Evening phone: (_____) _____

Relationship to student_____

HEALTH HISTORY FORM

FAMILY HISTORY							
RELATIONSHIP	**AGE**	**STATE OF HEALTH**	**IF DECEASED, AGE AND CAUSE OF DEATH**	**HAVE ANY OF YOUR IMMEDIATE RELATIVES HAD ANY OF THE FOLLOWING: (Please put check mark)**	**YES**	**NO**	**RELATIONSHIP**
Father				Alcohol/Substance abuse			
Mother				Cancer			
Brother				Diabetes			
Sister				Heart Disease/High blood pressure			
Spouse				Kidney disease			
Children				Neuromuscular disorder			
				Mental Illness/Depression			
				Tuberculosis			
Additional Sibling				Sudden death before age 50			
Additional Sibling				Other			

STUDENT MEDICAL HISTORY

Please check all that apply

- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Cancer
- ☐ Concussion
- ☐ COVID-19
- ☐ Diabetes
- ☐ Ears
- ☐ Eating Disorder
- ☐ Eyes
- ☐ Heart
- ☐ Kidney
- ☐ Liver
- ☐ Measles
- ☐ Mental Health
- ☐
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Rubella
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Thyroid
- ☐ Other

Comments:

_____

_____

Are you currently followed by a medical provider for a medical condition?	**Yes**	**No**
Reason:		
Are you currently followed by a medical provider for a mental health condition?	**Yes**	**No**
Reason:		
Have you had any surgical procedures?	**Yes**	**No**
If yes, list with dates:		
Do you exercise regularly?	**Yes**	**No**
Do you smoke or vape?	**Yes**	**No**
Do you consume alcohol? Number of drinks per week:	**Yes**	**No**
ALLERGIES		
Do you have any allergies? If so, please specify below, including the reaction.	**Yes**	**No**
Medication(s)/Reaction:		
Food(s)/Reaction:		
Other/Reaction:		
Do you carry an Epi-Pen?	**Yes**	**No**

If you have indicated above that you have a medical condition, chronic illness or concerning allergy, we encourage you to contact the Regis Center for Health and Wellness at 781-768-7290 to schedule a free consultation with a health care provider to discuss how we may be helpful.

HEALTH INSURANCE AND CONSENTS FORM

PRIMARY HEALTH INSURANCE INFORMATION

Health insurance company name: _____

Health insurance company address: _____

Insurance phone number: _____

Group name: _____

ID#:_____ Group#:_____

Name of subscriber: _____ Subscriber DOB: ___/___/___Relationship to insured: _____

Primary care physician: _____Physician phone number: _____

It is the responsibility of the student to obtain referrals or authorization, as required by your insurance company, for payment of services.

Student is responsible for all charges that are not covered by health insurance.

Please upload a copy of your insurance card (front and back). Note: *This form is NOT a waiver for the Regis student health insurance.*

MASSACHUSETTS IMMUNIZATION INFORMATION SYSTEMS (MIIS)

Regis College Health Services is required by law (M.G.L. c. 111, Section 24M) to participate in the Massachusetts Immunization System (MIIS) which is a confidential, electronic system that collects and stores vaccination records for Massachusetts resident of all ages. This program is operated by the Massachusetts Department of Public Health and is designated to help you along with your health care providers, schools and childcare centers, to keep track of the vaccinations that you have received. All residents of Massachusetts, including Regis College Students, will have their vaccine information entered into the MIIS. Your name, address, gender, date of birth, and health care provider's information will be entered to identify you within the MIIS. All this information given through MIIS is secure and confidential. Massachusetts's residents have the right to limit who may see their or their child's information in the MIIS. If you prefer that your or your child's immunization history, not be shared with other health care providers who use MIIS, please complete the MIIS Objection Form, see link: https://www.mass.gov/info-details/massachusetts-immunization-information-system-miis-forms#objection-(or-withdrawal-of-objection)-form-

CONSENT FOR MEDICAL TREATMENT

I grant permission to the staff of Regis College Center for Health and Wellness to provide medical treatment for illness, injury, immunizations or preventative care to this student. This includes emergency treatment (including transport to a local hospital, surgery and anesthesia) in the event of a serious illness or injury when parent or guardian cannot be reached. I also give consent for psychological and/or medical treatment, including medication, if necessary, should this student request such treatment while a student at Regis.

Student's Name (please print): _____ Student's Signature (Required):_____ Date:___/___/___

Parent/Guardian's Name (please print): _____ Parent/Guardian's Signature (Required):_____ Date:___/___/___

(Parent/Guardian name and signature required for all students under the age of 18)

CONSENT TO SHARE HEALTH INFORMATION

In order to monitor the health of students, faculty, and staff, Regis College discloses individual health information to certain partners and government agencies. Specifically, Regis College discloses health information to entities that operate systems or software programs that enable Regis College to monitor concerning symptoms, health testing, and vaccinations across the community. By signing below, I grant Regis College permission to make these disclosures.

Student's Name (please print): _____ Student's Signature (Required):_____ Date:___/___/___

Parent/Guardian's Name (please print): _____ Parent/Guardian's Signature (Required):_____ Date:___/___/___

(Parent/Guardian name and signature required for all students under the age of 18)

REGIS COLLEGE PHYSICAL EXAM FORM

Physical Examination must be within the past twelve months.
A health care provider must complete this form or supply comparable physical exam form.

Student's Name:_____ **Date of Birth:** _____/_____/_____ **Date of Exam:** ____/____/____
Last First MI Month Day Year Month Day Year

Hearing: Right _____ Left_____ Color Vision Normal: Yes/No Vision: R-20/___ Vision: L-20/___ with correction R-20/__ L-20/__

Height: _____ Weight: _____ BMI: _____ BP: _____ Pulse: _____

System	Normal	Describe Abnormality
1. Skin		
2 HEENT		
3. Lungs/Chest		
4 Breasts		
5. Heart/Vascular System		
6 Abdomen (rectal if indicated)		
7. Genito-urinary		
8. Gynecological		
9. Lymphatic		
10. Musculoskeletal		
11. Neurological		
12. Endocrine		
13. Psychological		
Recommended Labs: Hgb / Hct: _____ Cholesterol: _____ Glucose: _____ Protein: _____ Micro: _____		

CURRENT AND CHRONIC PROBLEMS:

1._____ 2. _____

3. _____ 4. _____

IF THE STUDENT IS UNDER YOUR CARE FOR A CHRONIC CONDITION OR SERIOUS ILLNESS, PLEASE PROVIDE US WITH ADDITIONAL INFORMATION TO ASSIST US IN PROVIDING CONTINUING CARE:

ALLERGIES

- Medications: _____ Reaction:_____
- Seasonal, insects, venom:_____ Reaction:_____
- Foods: _____ Reaction:_____

Does the student have an Epi-pen? _____

CURRENT MEDICATIONS

Medication Name	Reason for taking medication	Dosage	Frequency	Instructions

FIT FOR SPORTS

Applicant may participate in school/sports/activities without restriction/limitations. □ Yes □ No If no, please explain below:

Reason(s) for restricting participation:_____

HEALTH CARE PROVIDER'S SIGNATURE:

Health care Provider's Name (please print) _____ Signature_____

Office Address _____ Phone (_____)_____ Fax (_____)_____

Regis College
Center for Health and Wellness

Incoming Undergraduate Student Health Forms 2024/2025

First Name:_____ Last Name:_____ D.O.B. ____/____/____

REGIS COLLEGE CENTER FOR HEALTH AND WELLNESS IMMUNIZATIONS FORM:

Required Vaccines	Dates Received	MA State Requirements
Hepatitis B **(may be Hepatitis B OR Hepatitis A/B combined)**	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #3___/___/___ **OR** Positive Titer HBsAB Date:___/___/___ ***(copy of lab result required)***	**3 doses;** laboratory evidence of immunity acceptable; **2 doses of Heplisav-B given on or after 18 years of age are acceptable.**
Meningococcal Quadrivalent (Formerly MCV$)	**Vaccine Name:** _____ Single Dose:___/___/___ **OR Signed Waiver:**_____	**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 toward this requirement. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form found here:** https://www.mass.gov/doc/information-about-meningococcal-disease-meningococcal-vaccines-vaccination-requirements-and-the-waiver-for-students-at-colleges-and-residential-schools/download. Meningococcal B vaccine is not required and does not meet this requirement.
MMR (Measles, Mumps, Rubella) **OR individual vaccines or titers:** • **Measles** • **Mumps** • **Rubella**	#1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ **OR** Positive Titer Date:___/___/___ #1___/___/___ #2___/___/___ **OR** Positive Titer Date:___/___/___ #1___/___/___ #2___/___/___ **OR** Positive Titer Date:___/___/___ ***(copy of lab results required)***	**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.
Tdap (Tetanus, Diptheria, Pertussis)	Tdap:___/___/___ *If **greater than 10 years ago**, must also provide date of recent Td:___/___/___ or 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.
Varicella	#1___/___/___ #2___/___/___ **OR** Positive Titer Date:___/___/___ ***(copy of lab results required)*** **OR** History of disease: Yes___ No___ Date:___/___/___	**2 doses**; first dose must be given on or after the 1st birthday and second dose must be given ≥ 28 days after first dose; history of chicken pox as documented by clinician or laboratory evidence of immunity is acceptable. Birth in the U.S. before 1980 acceptable only for non-health science students.
STRONGLY RECOMMENDED & ADDITIONAL IMMUNIZATIONS	**Dates Received**	**Standing Dosing**
Influenza	**Vaccine Name:**_____ Single Dose:___/___/___	Single dose annually
Meningococcal Group B	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #3___/___/___	2 or 3 doses depending on vaccine and indication
Human Papillomavirus (HPV)	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #3___/___/___	2 or 3 doses depending on age at initial vaccination or condition
Hepatitis A	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #3___/___/___ #4___/___/___	2, 3 or 4 doses depending on vaccine or condition
COVID-19 Vaccines:	**Vaccine Name:** _____ Date: ___/___/___ **Vaccine Name:** _____ Date: ___/___/___	COVID-19 vaccines per CDC recommendations.

HEALTH CARE PROVIDER'S SIGNATURE:

Health care Provider's Name (Please Print):_____ Signature:_____ Date:____/____/____

Address: (Including City and State):_____

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

Regis College
Center for Health and Wellness

Incoming Undergraduate Student Health Forms 2024/2025

First Name:_____ Last Name:_____ D.O.B. ____/____/____

TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORMS

Please refer to this list of countries/territories with high TB incidence when responding to the questions below

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

Sources: *ACHA Guidelines, March 2024: Tuberculosis Screening and Targeted Testing of College and University Students.*
World Health Organization Global Health Observatory, Tuberculosis Incidence. Countries with incidence rates ≥ 20 cases per 100,000 population.

	PART 1: TUBERCULOSIS SCREENING QUESTIONS: (TO BE COMPLETED BY INCOMING STUDENT)	YES	NO
#1	Have you ever tested positive for Tuberculosis (TB)? ***If yes, when***:_____		
#2	Have you ever had close contact with persons known or suspected to have active TB disease? ***If yes, when***:_____		
#3	Were you born in a country or territory with high TB rate, as listed above? ***If yes, what country?***_____ ***If no, what country?*** _____***Date of entry to U.S.*** :____/____/____		
#4	Have you resided in or traveled to one or more of the countries or territories listed above for a period of one to three months or more? The significance of any travel exposure should be reviewed with a health care provider. ***If yes, what country?***_____ ***When:*** _____		
#5	Have you been a resident, volunteer and/or employee of high-risk congregate settings including correctional facilities, long-term care facilities, and/or homeless shelters, rehabilitation facility?		
#6	Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?		
#7	Have you been a member of any of the following groups that may have increased risk of latent TB infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?		
	Date of Form Completion: ____/____/_____		

- **If the answer to all of the above questions is NO**, no further testing or further action is required at this time. You do not need to complete pages 10 and 11 of this packet. Page 9 is the only page you will have to upload to CastleBranch.
- **If the answer is YES to question 1**, ***No additional TB testing*** (TST, IGRA) should be performed. ***HOWEVER,*** **your health care provider must complete pages 10 and 11 with additional testing and/or documentation as needed. Pages 9, 10 and 11 must be uploaded together.**
- **If the answer is YES to any of the questions 2-7**, Regis College requires that you receive ***TB testing within 6 months prior to the start of the semester***. **Your health care provider must complete pages 10 and 11 with additional testing and/or documentation as needed**. **Pages 9, 10 and 11 must be uploaded together.**

TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORMS

	PART 2: TUBERCULOSIS RISK ASSESSMENT: TO BE COMPLETED BY A HEALTH CARE PROVIDER	YES	NO
Please review and verify the information in ***Part 1, TB Screening Questions*** on the previous page. Per the CDC, TB blood tests are the preferred method of TB testing for people who have received the BCG vaccine.			
#1	Does the person have a history of a positive TB skin or IGRA blood test? Date of Test:_____ Type of TB test:_____ ***If yes***, please complete all sections of pages 2 and 3, as applicable.		
#2	Does the person have a history of receiving the Bacillus Calmette-Guerin (BCG) vaccine? ***If yes***, consider IGRA if possible.		
	PART 3: TUBERCULOSIS SYMPTOM SCREENING: TO BE COMPLETED BY A HEALTH CARE PROVIDER	**YES**	**NO**
#1	Cough (especially if lasting for 3 weeks or longer) with or without sputum production		
#2	Coughing up blood (hemoptysis)		
#3	Chest pain		
#4	Loss of appetite		
#5	Unexplained weight loss		
#6	Night sweats		
#7	Fever		
If YES to any of the above questions, **in Part 3**, student must proceed with additional evaluation to exclude active tuberculosis disease. **Your health care provider must complete pages 10 and 11 with additional testing and/or documentation as needed.**			

PART 4: TUBERCULIN SKIN TEST (TST): TO BE COMPLETED BY A HEALTH CARE PROVIDER

TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if no induration, write "0". The TST interpretation should be based on mm of induration as well as risk factors, see interpretation guidelines below.

Date Planted: _____/_____/_____ Time Planted: _____ Site Planted: _____ Manufacturer:_____

Lot Number: _____ Expiration Date: _____/_____/_____ Planted by: _____

Date Read: _____/_____/_____ Time Read:_____ Result: MM of induration:_____ Read By:_____

INTERPRETATION OF TUBERCULIN SKIN TEST: (Please use table below and circle response) **Negative / Positive.**

>5 mm is positive:

- recent close contacts of an individual with infectious TB
- persons with fibrotic changes on a prior chest x-ray, consistent with past TB disease
- organ transplant recipients and other immunosuppressed persons (including receiving equivalent of >15 mg/d of prednisone for >1 month.)
- HIV-infected persons

>10 mm is positive:

- Foreign born or travelers to the U.S. from high prevalence areas or who resided in one for a significant* amount of time
- injection drug users
- mycobacteriology laboratory personnel
- residents, employees, or volunteers in high-risk congregate settings
- persons with medical conditions that increase the risk of progression to TB disease including silicosis, diabetes mellitus, chronic renal failure, certain types of cancer (leukemia and lymphomas, cancers of the head, neck, or lung), gastrectomy or jejunoileal bypass and weight loss of at least 10% below ideal body weight.

>15 mm is positive:

- persons with no known risk factors for TB who, except for certain testing programs required by law or regulation, would otherwise not be tested.

TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORMS

PART 5: INTERFERON GAMMA RELEASE ASSAY (IGRA): TO BE COMPLETED BY A HEALTH CARE PROVIDER

Date of Test: _____/_____/_____ Type of Test: ☐ QuantiFERON-TB Gold Plus ☐ T-Spot ☐ other

Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Borderline (T-spot only)

Please attach a copy of the lab report.

PART 6: CHEST X-RAY (Required if TST or IGRA is POSITIVE: TO BE COMPLETED BY A HEALTH CARE PROVIDER

A chest x-ray is required if TST or IGRA is positive. Note: a single PA view is indicated in the absence of symptoms. If symptomatic, a PA and lateral view and sputum evaluation as indicated.

Date of Chest x-ray: _____/_____/_____

Result: ☐ Abnormal ☐ Normal Interpretation:_____

Additional Result Information: _____

Please attach a copy of the written chest x-ray report and lab reports, if indicated.

PART 7: MANAGEMENT OF POSITIVE TST OR IGRA: TO BE COMPLETED BY A HEALTH CARE PROVIDER

In deciding whether to recommend treatment of LTBI to individual patients, the clinician should weigh the likelihood of infection, the likelihood of progression to active tuberculosis infection, and the benefit of therapy. Students in the following groups are at increased risk of progression from LTBI to active TB disease and should be prioritized to begin treatment as soon as possible.

- ☐ Infected with HIV
- ☐ Recently infected with M. tuberculosis (within the past 2 years)
- ☐ History of untreated or inadequately treated TB disease, including persons with fibrotic changes on chest radiograph consistent with prior TB disease
- ☐ Receiving immunosuppressive therapy such as tumor necrosis factor-alpha (TNF) antagonists, systemic corticosteroids equivalent to greater than 15 mg of prednisone per day, or immunosuppressive drug therapy following organ transplantation
- ☐ Diagnosed with silicosis, diabetes mellitus. Chronic renal failure, leukemia, or cancer of the head, neck or lung
- ☐ Have had a gastrectomy or jejunoileal bypass
- ☐ Weigh less than 90% of their ideal body weight
- ☐ Cigarette and e-cigarette smokers and persons who abuse drugs and/or alcohol

	PART 8: MANAGEMENT OF POSITIVE TST OR IGRA: MEDICATION SECTION: TO BE COMPLETED BY A HEALTH CARE PROVIDER	YES	NO
#1	Was the patient educated and counseled on latent tuberculosis and advised to take medication because of the positive results?		
#2	Did the patient decline treatment at this time?		
#3	Did the patient agree to receive treatment at this time? • Indicate medication(s) prescribed: Start Date: _____/_____/_____ End Date: _____/_____/_____ _____ _____ _____ _____ • ***Students with a history of a positive TB test, who have not been treated for latent TB must have an annual symptom review with a health care provider.***		

PART 9: SIGNATURE OF HEALTH CARE PROVIDER

Signature of Health Care Provider | Printed Name | Date

Mailing Address | Office Phone | Office Fax Number

Regis College
Center for Health and Wellness

Dear Parent/Student:

As the Director of Regis College Center for Health and Wellness, I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningitis, and the regulations pertaining to meningococcal disease and vaccination.

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation and even death.

Massachusetts law requires all newly enrolled full-time students 21 years of age and under attending college to receive a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday and prior to the start of classes to protect against serotypes A, C, W and Y, or fall within one of the exemptions in the law listed below.

According to the Massachusetts Department of Public Health, students may begin classes *without* a certificate of immunization against meningococcal disease if:

1. the student has a letter from a physician stating that there is a medical reason why he/she cannot receive the vaccine (medical exemption);
2. the student (or the student's parent/legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief (religious exemption); or
3. the student (or the student's parent/legal guardian, if the student is a minor) signs the MDPH Meningococcal Waiver Form stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine (Meningococcal waiver exemption). You may download the MDPH Meningococcal Information and Waiver Form at: **https://www.mass.gov/doc/information-about-meningococcal-disease-meningococcal-vaccines-vaccination-requirements-and-the-waiver-for-students-at-colleges-and-residential-schools/download**.

If you have any questions or concerns, please call Health Services at (781) 768-7290.

Sincerely,

Tammi Magazzu
Tammi Magazzu, RN, WHNP-BC
Associate Dean and Medical Director
Regis College Center for Health and Wellness

Regis College
Center for Health and Wellness

STUDENT MEDICAL RECORD

A student's health information is confidential and protected by State and Federal Laws. Regis Health Services respects student confidentiality and is dedicated to protecting student rights.

A student's medical record is the property of Regis College Center for Health and Wellness. Privacy regulations prevent us from releasing any health information without the written consent of the patient, or where otherwise permitted by law.

We are required by law to obtain a signed informed consent for the release of information. As custodian of your medical record, we must therefore review your record before we copy it. If there is any mention of drug/alcohol abuse, sexual assault, sexually transmitted disease, physical abuse, HIV, AIDS, abortion or mental health treatment, you will be required to state in writing if you do or do not want that information released. The law restricts the recipient of health information from further disclosure. This means that we cannot make copies of records that we received from your previous providers, and you will have to request copies from them.

Requests for copies from Health Services may necessitate a search through old records and may take up to 7 business days to process.

REGIS COLLEGE

CENTER FOR HEALTH AND WELLNESS

SERVING THE STUDENTS, FACULTY, AND STAFF OF REGIS COLLEGE

Health Center Hours:

Monday from 9 AM to 7 PM
Tuesday through Friday 9 AM to 4 PM

Health Services Team:

Tammi Magazzu - Medical Director, WHNP
Rebecca Hill - Clinical Care Leader, FNP
Margaret Duggan - WHNP
Erin Tetler - FNP
Cheryl Murphy - RN
Amy Bouvier - RN
Beth DeArias - Administrative Assistant
Stacey Cloutman - Billing Coordinator
Eddie Hand - Compliance Coordinator

Conditions Treated & Services Offered:

Services are billed through the student's insurance.

- Sore throats, coughs, earaches, cold and flu
- Eye infections, irritations, or injuries
- Asthma, bronchitis, pneumonia
- Vomiting and diarrhea
- Wounds, dressing changes, suture removal
- Minor sprains or strains
- Muscle aches or pains
- Urinary issues
- Routine gynecological exams
- Gender-related health issues
- Physical exams (work, school, sports, camp, and clearances
- Strep Testing (Rapid & Culture)
- Mono Testing
- COVID-19 rapid testing
- Splinting
- Phlebotomy Lab Services
- Immunizations & Flu Shots
- TB testing
- Other minor illnesses or injuries

Delivery of Prescription Medications Five Day a Week, (M-F):

- Keyes Drug in Newton, MA will deliver prescription medications to Regis Center for Health and Wellness for students to pick-up, (excludes holidays and campus closures).

FOR INFORMATION REGARDING MANDATORY HEALTH FORMS FOR INCOMING STUDENTS PLEASE VIST THE LINK BELOW:

regiscollege.edu/medicalforms

PHONE: 781-768-7290 FAX: 781-768-7288
EMAIL: HEALTH.SERVICES@REGISCOLLEGE.EDU
235 WELLESLEY STREET, BOX 11
WESTON, MA 02493

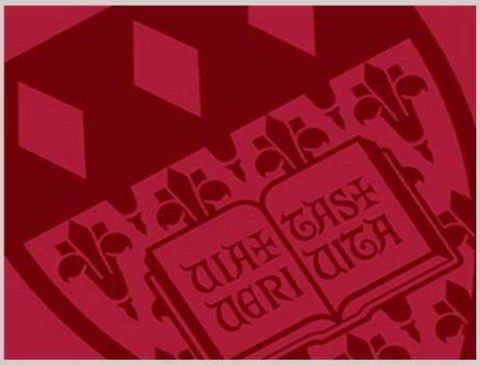
COUNSELING SERVICES

The Counseling Center is dedicated to supporting the educational mission of Regis College by providing professional mental health services to students. All enrolled Regis College students who study on the Weston Campus are welcome to utilize our confidential counseling center by visiting the Center for Health and Wellness. Students are offered twelve free sessions of counseling each academic year. Sessions after the first twelve are provided at the counselor's discretion based on clinical necessity. Mental Health professionals are on campus daily (Monday through Friday) and services are available year-round. Students located in Massachusetts can choose to have video counseling sessions if clinically appropriate.

Clinic Hours

- Monday 9 a.m. to 5 p.m.
- Tuesday 9 a.m. to 5 p.m.
- Wednesday 9 a.m. to 5 p.m.
- Thursday 9 a.m. to 5 p.m.
- Friday 9 a.m. to 4 p.m.

Evening hours are available by Telehealth on Mondays and Wednesdays



Counseling Services Team

Kathryn S. Klickstein - Director of Counseling
Serena Cardoso - Assistant Director of Counseling
Lindsay Miller - Counselor
Stacey Villeda - Counselor

We offer individual counseling, consultations, mental health assessments, substance abuse assessments and counseling, medication evaluation and management, coordination with outside professionals, referrals to off-campus services, wellness groups and workshops.

Appointments

Stop by Health Services or call 781.768.7290 to schedule an appointment. Same day appointments are available as needed.
For all mental health emergencies after clinic hours, contact the Regis College Police Department at 781.768.7777

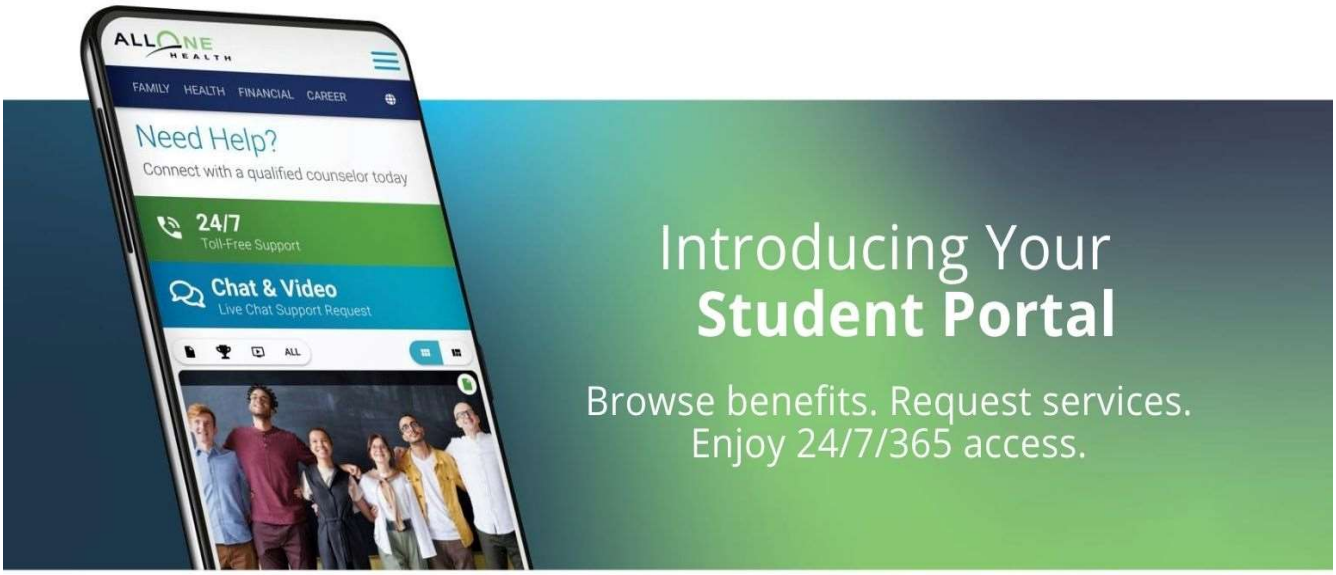
For urgent counseling issues and to speak with a member of our counseling staff when the Center for Health and Wellness is closed, please contact the Regis College Police Department at 781.768.7111 and ask to be connected to the on-call Student Affairs staff member

After Hours Counseling

All Regis students are welcome to use our Student Assistance Program (formerly called Talk One2One). This Student Assistance Program from AllOne Health provides students with 24/7 instant access to phone counseling with a mental health professional.

For 24/7 "in the moment support" with a mental health professional call: 800.756.3124

EMAIL:
COUNSELING.SERVICES@REGISCOLLEGE.EDU



Your Assistance Program offers a wide range of benefits to help improve mental health, reduce stress and make life easier—all easily accessible through your student portal.

Request a Mental Health Session

Request counseling by submitting an online form or live chat. Choose from in-person or virtual counseling options to meet your needs.

Request Referrals & Resources

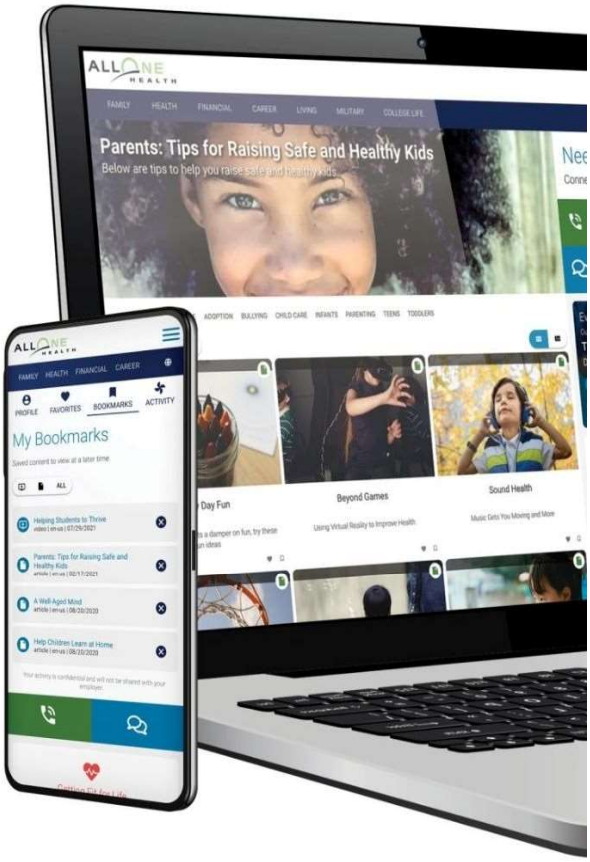
Submit a request for family care and lifestyle support including childcare and eldercare referrals, legal and financial consultation, personal assistant referrals and medical advocacy consultation.

Explore Thousands of Self-Care Articles & Resources

Health and lifestyle assessments, interactive checklists, soft skills courses, podcasts, resource locators, exclusive discounts, and expansive articles on whole health and well-being.

Visit Your Online Financial Center

Featuring worksheets, calculators, and a wide range of financial resources and tools to help reach personal goals and build financial wellness.



Getting Started Is Easy

1. Visit: https://myassistanceprogram.com/students and click on "Log In to the Student Portal"
2. Register to create a new account using your institution code: **regissa**
3. A confirmation email will be sent to complete the pro ce ss

Call: 800-756-3124

Visit: https://myassistanceprogram.com/students
Code: regissa

ALLONE HEALTH