Dear Incoming Student:

Health Services would like to welcome you to Regis College. Massachusetts law requires that all incoming students provide proof of immunization, have a physical examination prior to their arrival on campus, and complete their health forms. Attached you will find health forms that are to be filled out by you and your health care provider. If immunization requirements have been completed, please return all of your completed forms to Health Services on/before July 15th for fall admission and January 15th for winter admission. If additional vaccines are needed to meet the state requirements, please return all other completed forms by July 15th/January 15th. Failure to do so could result in your inability to move into campus housing or register for classes. If your completed medical report and immunization records are not in by the end of the first week of classes a “hold” will be placed on your registration which will impact your ability to add/drop courses, register for next semester and view/receive your grades. In addition, you will be charged an administrative late fee of $25. Students are responsible for complying with this deadline without exception.

Massachusetts State law requires that all students submit a medical record. The following information must be submitted:

- Past medical history
- Physical examination (within the past 12 months)
- Immunization information (to include one Meningitis vaccine within the past 5 years OR completion of Meningococcal waiver for all resident students)
- Tuberculin skin test results dated after July 1st of this year (recent chest x-ray results required for all positive ppd results – see form titled “Medical Evaluation For Latent Tuberculosis Infection”)
- Signature of student, if 18 years of age, giving permission for routine and emergency treatment
- Signature of parent, if student is under 18 years of age, giving permission for routine and emergency treatment
- Health Insurance information along with a photocopy of the front and back of insurance card

Your health information is confidential and protected by State and Federal Laws. The information you submit is maintained by Regis College Health Services in the strictest confidence. HIPAA regulations prevent us from releasing or discussing any health information without written consent of the patient, except when there is imminent danger to you or to others, or when required by law.

Massachusetts law requires all undergraduate students taking nine (9) credits or more and all graduate students taking 6.75 credits or more to either demonstrate proof of comparable health insurance coverage or purchase a Qualifying Student Health Insurance Plan through their institution of higher education. In order to assure that ALL Regis College students are properly insured to meet the state law, all students are initially charged on their student account for the cost of the Harvard Pilgrim Health Care Student Injury and Sickness Insurance Plan. It is then your choice whether to enroll in this insurance plan or waive the insurance and remain on your family or individual plan. Health insurance information will be mailed to you separately with instructions on enrolling or waiving the student health insurance.

We are pleased that you have selected Regis College and welcome you to campus. If you have any questions or concerns, please call Health Services at (781) 768-7290.

Yours truly,

Dianna Jones, DNP
Director of Health Services
HEALTH REPORT

To be filled out by student in its entirety

Name: _________________________________________________ Date of Birth: _______ / ______ / ______ Gender: Male/ Female

Permanent Address: ____________________________________________ Regis Student ID#: ____________________________

Street
City State Zip Country Birthplace: __________________________

Home Telephone: (______) ________________________________ Area code
Student Cell: (______) ________________________________ Area code

Email: _________________________________ Regis Athlete: Yes _____ No _____

Date entering Regis: ________________ Expected Date of Graduation: ________________

Status: Undergraduate _____ Graduate _____ Nursing/Health Science student _____ Resident ________ Commuter_______

Fathers Name: ________________________________ Mothers Name: ________________________________

Father’s daytime phone: (______) __________________________ Area code
Mother’s daytime phone: (______) __________________________ Area code

PRIMARY EMERGENCY CONTACT (1st to call):

1. Name:__________________________________________
Address:__________________________________________
Daytime phone: (______) __________________________
Evening phone: (______) __________________________
Relationship to student: __________________________

CONSENT FOR MEDICAL CARE

Student Name: ________________________________

I grant permission to the staff of Regis Community Health Services to provide medical treatment for illness, injury or immunizations to the above named student. This includes emergency treatment (including transport, surgery and anesthesia) in the event of a serious illness or injury when parent or guardian cannot be reached.

_________________________ ______________________
Students Signature (REQUIRED) Date

Parent/ Guardian Signature ______________________ Date
(Required if student is under 18 years of age)

ALTERNATE EMERGENCY CONTACT:

2. Name:__________________________________________
Address:__________________________________________
Daytime phone: (______) __________________________
Evening phone: (______) __________________________
Relationship to student: __________________________

PRIME HEALTH INSURANCE INFORMATION

Name of Insurance Co.: ________________________________
Address:__________________________________________
ID#: __________________________ Group#: __________________________
Name of Subscriber: ________________________________
Primary care physician: __________________________ Phone: __________________________

It is the responsibility of the student to obtain referrals or authorization for lab appointments, tests, x-rays, hospitalizations, etc. required by your insurance company. Student is responsible for all charges that are not covered by health insurance. Please attach a copy of your insurance card (front and back).

NOTE: This form is NOT a waiver for the Regis College student health insurance.
**Student’s Name:**

**FAMILY HISTORY**

<table>
<thead>
<tr>
<th>Age</th>
<th>State of Health</th>
<th>Age and Cause of Death</th>
<th>Have any of your immediate relatives had any of the following:</th>
<th>Yes</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td>Alcoholism/Substance abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td></td>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td></td>
<td>Heart Disease/High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td>Kidney disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td></td>
<td>Neuro muscular disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mental Illness/Depression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PERSONAL HISTORY:** Do you have now or have you ever had (check all that apply and follow with date):

- Abnormal Pap Smear
- Anemia
- Anorexia Nervosa
- Anxiety Disorder
- Appendectomy
- Arthritis
- Asthma
- Bulimia
- Cancer/Malignancy
- Chickenpox
- Colitis/Ileitis
- Diabetes
- Depression
- Menstrual disorders
- Migraines
- Pelvic Inflammatory Disease
- Polycystic Ovary Syndrome
- Sickle Cell Disease
- Tuberculosis
- Ulcer/Stomach Problem
- Other

**GYNECOLOGICAL HISTORY** (Check all that apply):

- Irregular periods
- Breast lumps/fibrocystic disease
- Use contraception:
- Preeclampsia:
- Pelvic Inflammatory Disease
- Pregnancy (live births): 
- Abortion/miscarriage:
- Menorrhagia:
- Menstrual cramps:
- Menstrual PMS:
- Heavy bleeding:
- Other:

**INPATIENT HOSPITALIZATIONS:** Please list all medical/psychiatric hospitalizations, dates, diagnosis and surgeries:

**MEDICATIONS:** Please list all (prescription and over-the-counter) including birth control, asthma medications, supplements, etc.

**ALLERGIES:** None Known

If yes, please specify including medication, insect, food, etc.:

- Type of reaction:

1a. Do you exercise? Never Occasionally 3-5 times/week Daily

1b. What type of exercise?

2. Do you wear a seatbelt? Always Sometimes Never

3a. Do you follow any diets? No Yes

3b. What kind?

4. Are you concerned about your eating habits? Yes No

5. Would you describe your weight as?
- Underweight
- Just right
- Overweight

6. Do you smoke cigarettes? No Yes How many/day?

7. Do you now or have you ever used recreational drugs? No Yes Which ones?

8a. Do you drink alcohol? No Yes How often?

8b. When you drink, how many do you usually have?

9. Are you concerned about your drinking/drug use? No Yes

10. Do you often feel anxious, overwhelmed or depressed? No Yes

11. Are you currently in counseling/therapy? No Yes

12. Have you ever been in therapy? No Yes

13. Is there anything else we need to know about your health?
# Physical Examination

Physical Examination must be within the past twelve months. A health care provider must complete this form.

Preprinted physical exam form from physician indicating clearance to attend/participate in program will also be accepted.

## Student’s Name:

Date of exam: __ / __ / __

<table>
<thead>
<tr>
<th>System</th>
<th>Normal</th>
<th>Describe Abnormality</th>
<th>Lab Work (if available)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skin</td>
<td></td>
<td></td>
<td>Date</td>
</tr>
<tr>
<td>2. HEENT</td>
<td></td>
<td></td>
<td>Urinalysis</td>
</tr>
<tr>
<td>4. Breasts</td>
<td></td>
<td></td>
<td>Glucose</td>
</tr>
<tr>
<td>6. Abdomen (rectal if indicated)</td>
<td></td>
<td></td>
<td>Micro.</td>
</tr>
<tr>
<td>7. Genito-urinary</td>
<td></td>
<td></td>
<td>Hgb/Hct</td>
</tr>
<tr>
<td>8. Gynecological</td>
<td></td>
<td></td>
<td>Cholesterol</td>
</tr>
<tr>
<td>9. Lymphatic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Musculoskeletal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Neurological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Endocrine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Psychological</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Current Major and Chronic Problems

1. _______________________________

Acute or Minor Problems

1. _______________________________

2. _______________________________

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.

The applicant _____ does _____ does not have a loss of or seriously impaired function of a paired organ.

ALLERGIES (medications, foods, insects, venom)______________________________________________________________

Type of reaction_____________________________________________________________ Does the student have an Epi-pen? ______

CURRENT MEDICATIONS (all prescription and OTC)______________________________________________________________

Applicant may participate in school/clinical placements/sports: _____ without reservation; _____ with the following restrictions________________________________: _____ should not participate in school/clinical placements/sports.

Reasons for limiting activity or sports__________________________________________________________

### HEALTH CARE PROVIDER

Name (please print) ___________________________ Signature ___________________________

Address _____________________________________ Phone (______) ____________________ Fax (______) ____________

Please mail this completed form to: Regis Community Health Services
235 Wellesley Street
Box 11
Weston, MA 02493-1571
MASSACHUSETTS LAW (College Immunization Law, Chapter 76, Section 15c) and Regis College require verification of immunity for measles, mumps, rubella, tetanus-diphtheria, hepatitis B and varicella. Exact dates are required for all immunizations and/or serological test results. If serology titer is done, please attach copy of report. If serology titer indicates lack of immunity, vaccines must be administered.

Student’s name: ___________________________________________ M / F_       Date of birth: ___/___/_____

Last First MI       circle       Month Day Year

REQUIRED IMMUNIZATIONS

A. MMR (Measles, Mumps, Rubella) (2 doses required OR results of antibody titer proving immunity)

Dose 1: Immunized on or after first birthday       Date: ___/___/_____

Dose 2: Given at least one month after dose 1       Date: ___/___/_____

OR:

Measles (rubeola) serology immune titer value*_________       Date: ___/___/_____

Interpretation: _____ Immune _____ Not Immune

(*include copy of lab results)

Mumps serology immune titer value*_________       Date: ___/___/_____

Interpretation: _____ Immune _____ Not Immune

(*include copy of lab results)

Rubella serology immune titer value*_________       Date: ___/___/_____

Interpretation: _____ Immune _____ Not Immune

(*include copy of lab results)

B. TETANUS-DIPHTHERIA-ACELLULAR PERTUSSIS (Tdap)

(one dose of tdap is required for all health science students)

Tdap within the past 10 years       Date: ___/___/_____

C. HEPATITIS B (3 doses AND results of Hepatitis B surface antibody proving immunity)

Dose 1: ___/___/_____

Dose 2: ___/___/_____

Dose 3: ___/___/_____

Documentation of a positive antibody titer* (HbsAB) (*include copy of lab results)

_____ Reactive _____ Non-reactive       Date: ___/___/_____

If titer result is negative, student is required to follow up with clinician as he/she may require additional doses of immunization.

D. MENINGOCOCCAL VACCINE – within the past 5 years or completion of a signed waiver for all resident students

(Recommended for all students)       Date: ___/___/_____

E. VARICELLA (2 doses OR results of titer* proving immunity) (having had chicken pox does not satisfy requirement)

Dose 1: ___/___/_____

Dose 2: ___/___/_____

Varicella serology immune titer value*_________       Date: ___/___/_____

Interpretation: _____ Immune _____ Not Immune

(*include copy of lab results)

If titer result is negative, student is required to receive the series of two vaccinations (document 2 doses above)

HEALTH CARE PROVIDER

Name (Please print) ___________________________________________ Signature ___________________________________________

Address ___________________________________________ Phone (______)______________ Fax (______)_____________

Please mail this completed form to: Regis Community Health Services
235 Wellesley Street
Box 11
Weston, MA 02493-1571

Revised 06/21/2016
STUDENTS NAME: ___________________________________________ DATE: _____/_____/_______

PLEASE NOTE: If patient has had a POSITIVE TUBERCULIN SKIN TEST in the past, the test should not be repeated. Go to Section B below and complete the TB Symptom Review form.

A. TUBERCULIN SKIN TEST (Mantoux/Intermediate PPD)

Test must be read by a healthcare provider 48-72 hours after administration. If no Induration, mark “O”.
Result of multiple puncture tests, such as Tine or Mono-Vac, are not accepted.

Date test administered: _____/_____/_____ Date test read: _____/_____/_____ Result: _______mm of induration

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>POSITIVE RESULT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent contact with a case of tuberculosis; HIV-infected persons; persons</td>
<td>5 mm or more</td>
</tr>
<tr>
<td>who are immunosuppressed for other reasons</td>
<td></td>
</tr>
<tr>
<td>Born in a country that has a high rate of tuberculosis; traveled/lived</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>for a month in a country that has a high rate of TB within the past 5</td>
<td></td>
</tr>
<tr>
<td>years</td>
<td></td>
</tr>
<tr>
<td>Persons working in clinical conditions that place them at high risk;</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>previous negative PPD</td>
<td></td>
</tr>
<tr>
<td>No risk factors</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

B. If tuberculin Skin Test is POSITIVE, now or by history, the following are required:

1. Date of positive PPD: _____/_____/_______

2. Chest x-ray: (attach report, NOT the x-ray) _____/_____/_______
   _____ Normal _____ Abnormal ____________________________________________
   (Describe)

3. Clinical Evaluation:
   _____ Normal _____ Abnormal ____________________________________________
   (Describe)

4. Treatment:
   _____ No _____ Yes _____________________________________________________
   (Drug, dose, frequency and dates)

Healthcare provider signature: (Required) __________________________ DATE: _____/_____/_______
Healthcare Provider Name (Please print): ___________________________ Phone: (______)____________________
Regis TB Symptom Review
(for those testing positive on PPD tuberculin [TB] skin test)

Nursing Student (Print) ____________________________ ______________

This assessment has 2 parts and is being done as an annual TB symptom review. If the health care provider completing PART 2 below deems necessary, further follow-up will be identified below and the Nursing Student will provide this original form and any other documentation of follow-up. Student should keep a copy for your files at home.

PART 1: (Completed by student prior to seeing Health Care Provider)

TB Symptoms Review                           History of BCG? Yes

NO

1. Are you currently exhibiting any of the following symptoms of tuberculosis? Have you had any of the following within the last 12 months?
   - □ Yes □ No Cough lasting longer than 3 weeks
   - □ Yes □ No Coughing up blood
   - □ Yes □ No Fever
   - □ Yes □ No Weight loss
   - □ Yes □ No Night sweats

If the answer is “Yes” to any of the symptoms listed above, please state when symptoms first began; how long symptoms have occurred; and if student has been evaluated by physician for symptoms. ________________________________________________

2. □ Yes □ No Is any person living in your household exhibiting any symptoms of tuberculosis that are listed above? If the client answered “Yes”, please list the symptoms. ________________________________________________

3. □ Yes □ No Have you ever had a chest x-ray done to rule out tuberculosis? If the client answered “Yes”, please state when the chest x-ray was done; the name of the physician; and the address and phone number of physicians/agency where it was done.

4. □ Yes □ No Have you ever received medication for active tuberculosis disease or preventive treatment for TB infection? If the client answered “Yes”, please state name of medications; when the medication was started and completed. ________________________________________________

Signature of Student ____________________________ Date ____________

PART 2 (Completed by Physician or Nurse Practitioner):

Printed/Typed name of Health Provider (or legible stamp), indicating name/title:

Health Care Agency affiliation: __________________ (city/state) __________________

Signature of Health Care Physician/ Nurse Practitioner: __________________ Date ____________

Assessment: ________________________________________________

Any further follow-up, other than annual review questionnaire, in 12 months.

TB annual survey_2016 vaccines.doc
Dear Parent/Student:

As the Director of Regis College Health Services, 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 undergraduate and graduate students at post-secondary schools who will be living in a dormitory to provide written documentation of having received the meningococcal vaccine (within the last 5 years) at least 2 weeks prior to beginning classes, unless they have a medical or religious exemption, or have signed the enclosed waiver declining the vaccine.

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 developed waiver 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). This waiver can be found at:
   http://www.regiscollege.edu/UserFiles/File/campus_community/healthcare_services/Meningococcal_Waiver.pdf

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

Sincerely,

Dianna Jones

Dianna M. Jones, DNP
Director of Health Services
Regis College
YOUR MEDICAL RECORD

Your health information is confidential and protected by State and Federal Laws. Regis Community Health Services respects student confidentiality is dedicated to protecting your rights.

Your medical record is the property of Regis Community Student Health Services. HIPAA regulations prevent us from releasing any health information without written consent of the patient or the parent/legal guardian if the patient is under age 18. The Health Center will not release any health information to parents or College staffs other than Health or Counseling center clinicians without the students’ express written authorization except as required by law.

We are required by law to obtain a signed informed consent for 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 usually take 7 days to process. There will be a $5.00 administrative processing fee for each request. We appreciate as much notice as possible.