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)
- Tuberculosis Questionnaire
- 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 emailed 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
To be filled out by student in its entirety

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

Permanent Address: _______________________________________ Regis Student ID#: ______________________

City State Zip Country Birthplace: _________________________

Home Telephone: (______) ______________________ Student Cell: (______) ______________________

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: (______) ______________________ Mother's daytime phone: (______) ______________________

Area code Area code

PRIMARY EMERGENCY CONTACT (1st to call):

1. Name: ____________________________________________

Address: ____________________________________________

Daytime phone: (______) _____________________________

Evening phone: (______) _____________________________

Relationship to student: ____________________________

ALTERNATE EMERGENCY CONTACT:

2. Name: ____________________________________________

Address: ____________________________________________

Daytime phone: (______) _____________________________

Evening phone: (______) _____________________________

Relationship to student: ____________________________

CONSENT FOR MEDICAL CARE

Student Name: ____________________________

I grant permission to the staff of Regis College 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)

PRIMARY 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.
MEDICAL HISTORY

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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td>Alcoholism/Substance abuse</td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td>Cancer</td>
<td></td>
</tr>
<tr>
<td>Brothers</td>
<td></td>
<td>Diabetes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart Disease/High blood pressure</td>
<td></td>
</tr>
<tr>
<td>Sisters</td>
<td></td>
<td>Kidney disease</td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td>Neuromuscular disorder</td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sudden death before age 50</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other</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
- Gynecological Problem
- Heart murmur/Click
- Heart disease/problem
- HIV Infection/disease
- Impaired Mobility
- Kidney Stone
- Learning Disability
- Malaria
- Migraines
- Mononucleosis
- Neurologic Problem
- Pneumothorax
- Psychological Problem
- Positive TB Test
- Rheumatic Fever
- Seizure Disorder
- Sickle Cell Disease
- Testicular Disease/Problem
- Thyroid Problem
- Tuberculosis
- Ulcer/Stomach Problem
- Other: ____________________________

GYNECOLOGICAL HISTORY (Check all that apply):

- Age at onset of menses: ____________
- Length of cycle: ____________
- Date of last Pap smear: ____________
- Result: ____________________________
- Have you ever had an abnormal Pap? Yes ______ No _______
- Colposcopy? Yes ______ No _______
- Date: ________
- Use contraception: ____________
- Pregnancy (live births)#: ________
- Abortion/miscarriage#: ________
- Irregular periods
- Breast lumps/fibrocystic disease
- No periods
- Pelvic Inflammatory Disease
- Painful cramps
- Genital Herpes (HSV)
- Bleeding between periods
- Genital Warts (HPV)
- Polycystic Ovary Syndrome
- Other sexually transmitted disease
- 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 Yes

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

Type of reaction:

1. Do you exercise? Never □ Occasionally □
2. Do you wear a seatbelt? Always □ Sometimes □ Never □
3. Do you follow any diets? No □ Yes □
4. What kind? ____________________________
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?
8. Do you drink alcohol? No □ Yes □ How often? ________
9. When you drink, how many do you usually have? ________
10. Are you concerned about your drinking/drug use? 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 strongly recommended within the past twelve months. A health care provider must complete this form.

**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></td>
</tr>
<tr>
<td>8. Gynecological</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Lymphatic</td>
<td></td>
<td></td>
<td>Hgb/Hct</td>
</tr>
<tr>
<td>10. Musculoskeletal</td>
<td></td>
<td></td>
<td>Cholesterol</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. ________________________________
2. ________________________________

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.

ALLEGIES (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/sports/activities: _____ without reservation; _____ with the following restrictions ________________________________; _____ should not participate in school/sports/activities.

Reasons for limiting activity or sports ________________________________

**HEALTH CARE PROVIDER**

Name (please print) ___________________________ Signature ___________________________

Address ___________________________ Phone (______) _______ Fax (______) _______

Please mail this completed form to: Regis College 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:___/___/______

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 full time undergraduate and graduate students and all health science students)

Tdap within the past 10 years Date:_______/_______/_______

Td (if also given within the past 10 years) Date:_______/_______/_______

C. HEPATITIS B VACCINE – (3 doses required or results Hepatitis B surface antibody proving immunity)

Dose 1:_______/_______/_______ Dose 2:_______/_______/_______ Dose 3:_______/_______/_______

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

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

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 VACCINE (2 doses required)

Dose 1:_______/_______/_______ Dose 2:_______/_______/_______

OR: Varicella serology immune titer value*__________ Date:_______/_______/_______

Interpretation: _____ Immune _____ Not Immune (*include copy of lab results)

OR: History of disease (Chicken Pox) Date:_______/_______/_______

HEALTH CARE PROVIDER

Name (Please print)____________________________________Signature__________________________

Address___________________________________________Phone (______)____________Fax (______)____________

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

REQUIRED for all undergraduate students to be completed and returned with Health Report

NAME: _______________________________________________

COUNTRY OF BIRTH: ________________________________

DATE: ___________________________________

1. Were you born in one of the countries listed below?    YES  NO

2. Have you lived with, or had close contact with anyone who had tuberculosis?    YES  NO

3. Does anyone living in your household have a positive skin test for tuberculosis?    YES  NO

4. Have you lived or had extensive travel outside the U.S. within the past five years to any of the countries listed below?    YES  NO

5. Do you or anyone in your household have AIDS or HIV infection?    YES  NO

6. Do you or any members of your household use intravenous drugs or other street drugs?    YES  NO

7. Have you worked or lived in a potentially high-risk congregate setting such as prison/jail, long term care facility, homeless shelter, residential facility for persons with HIV/AIDS, drug treatment center, etc?    YES  NO

• HIGH RISK: If you answer YES to one or more of the above questions, Regis College requires that you have a tuberculin skin test (Mantoux Test/Intermediate PPD) to check for latent tuberculosis infection. Your health care provider must complete the enclosed Medical Evaluation for Latent Tuberculosis Infection form.

• LOW RISK: If you answer NO to all the above questions, a tuberculin test is not required.

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

<table>
<thead>
<tr>
<th>Afghanistan</th>
<th>Comoros</th>
<th>Iran</th>
<th>Myanmar</th>
<th>South Africa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angola</td>
<td>Congo</td>
<td>Kazakhstan</td>
<td>Namibia</td>
<td>Sri Lanka</td>
</tr>
<tr>
<td>Armenia</td>
<td>Congo, DR</td>
<td>Kenya</td>
<td>Nepal</td>
<td>Sudan</td>
</tr>
<tr>
<td>Azerbaijan</td>
<td>Cote d’evoire</td>
<td>Kiribati</td>
<td>New Caledonia</td>
<td>Suriname</td>
</tr>
<tr>
<td>Bahamas</td>
<td>Croatia</td>
<td>Korea, DR</td>
<td>Nicaragua</td>
<td>Swaziland</td>
</tr>
<tr>
<td>Bahrain</td>
<td>Djibouti</td>
<td>Korea, REP</td>
<td>Niger</td>
<td>Syrian Arab Republic</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>Dominican Republic</td>
<td>Kyrgyzstan</td>
<td>Nigeria</td>
<td>Tajikistan</td>
</tr>
<tr>
<td>Belarus</td>
<td>Ecuador</td>
<td>Lao PDR</td>
<td>Niue</td>
<td>Tanzania, UR</td>
</tr>
<tr>
<td>Benin</td>
<td>El Salvador</td>
<td>Latvia</td>
<td>Northern Mariana Islands</td>
<td>Thailand</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Equatorial Guinea</td>
<td>Lesotho</td>
<td>Pakistan</td>
<td>Togo</td>
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<tr>
<td>Bolivia</td>
<td>Eritrea</td>
<td>Liberia</td>
<td>Palau</td>
<td>Tokelau</td>
</tr>
<tr>
<td>Bosnia &amp; Herzegovina</td>
<td>Estonia</td>
<td>Lithuania</td>
<td>Panama</td>
<td>Turkmenistan</td>
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<tr>
<td>Botswana</td>
<td>Ethiopia</td>
<td>Macedonia TFYR</td>
<td>Papua New Guinea</td>
<td>Uganda</td>
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<tr>
<td>Brazil</td>
<td>Gabon</td>
<td>Madagascar</td>
<td>Paraguay</td>
<td>Ukraine</td>
</tr>
<tr>
<td>Brunel Darussalam</td>
<td>Gambia</td>
<td>Malawi</td>
<td>Peru</td>
<td>Uzbekistan</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>Georgia</td>
<td>Malaysia</td>
<td>Philippines</td>
<td>Vanuatu</td>
</tr>
<tr>
<td>Burundi</td>
<td>Ghana</td>
<td>Maldives</td>
<td>Portugal</td>
<td>Vietnam</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Guam</td>
<td>Mali</td>
<td>Romania</td>
<td>Yemen</td>
</tr>
<tr>
<td>Cameroon</td>
<td>Guatemala</td>
<td>Marshall Islands</td>
<td>Russian Federation</td>
<td>Zambia</td>
</tr>
<tr>
<td>Cape Verde</td>
<td>Guinea</td>
<td>Mauritania</td>
<td>Sao Tome &amp; Principe</td>
<td>Rwanda</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>Guinea, Bissau</td>
<td>Mauritius</td>
<td>Senegal</td>
<td>Zimbabwe</td>
</tr>
<tr>
<td>Chad</td>
<td>Guyana</td>
<td>Micronesia</td>
<td>Moldova, Rep.</td>
<td>Sierra Leone</td>
</tr>
<tr>
<td>China</td>
<td>Haiti</td>
<td>Mongolia</td>
<td>Mongolia</td>
<td>Solomon Islands</td>
</tr>
<tr>
<td>China, Hong Kong SAR</td>
<td>Honduras</td>
<td>Morocco</td>
<td>Somalia</td>
<td></td>
</tr>
<tr>
<td>China, Macao SAR</td>
<td>Indonesia</td>
<td>Mozambique</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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.

### 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.

<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 who are immunosuppressed for other reasons</td>
<td>5 mm or more</td>
</tr>
<tr>
<td>Born in a country that has a high rate of tuberculosis; traveled/lived for a month in a country that has a high rate of TB within the past 5 years</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>Persons working in clinical conditions that place them at high risk; previous negative PPD</td>
<td>10 mm or more</td>
</tr>
<tr>
<td>No risk factors</td>
<td>15 mm or more</td>
</tr>
</tbody>
</table>

Date test administered: _____/_____/______ Date test read: _____/_____/_____ Result: _______ mm of induration

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

1. **Date of positive PPD:** _____/_____/______

2. **Chest x-ray:** Required (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: (______)_____________________

---

Medical Evaluation for Latent Tuberculosis Infection

(To be completed by a healthcare professional)

Please refer to Tuberculosis Risk Questionnaire form before completing.
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 College Health Services respects student confidentiality is dedicated to protecting your rights.

Your medical record is the property of Regis College 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.