REGIS
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 graduate students to provide proof of required immunizations and medical insurance information. You must complete, and upload all required medical documentation to our secure upload site. **To access the health forms and the upload site, click here or visit: regiscollege.edu/medical forms.**

Regis athletes must complete this process **in addition to** the forms required by the athletic department.

Due Dates:
All health forms must be electronically uploaded to the Regis Center for Health and Wellness, via the secure site, no later than:
→ **Tuesday, July 15th, 2025, for fall enrollment**
→ **Monday, January 5th, 2026, for spring enrollment**

Failure to comply with the above deadlines 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.

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

For students seeking an accommodation for documented disabilities: 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 or email: healthcompliance@regiscollege.edu.

Thank you,

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

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HEALTH FORMS INSTRUCTIONS AND CHECKLIST
DUE DATES:
→ **Tuesday, July 15th, 2025, for fall enrollment**
→ **Monday, January 5th, 2026, for spring enrollment**

√	FORMS	INSTRUCTIONS: Please write your name, date of birth and date in the upper right corner of each page of the Health Forms.
	Page 1: Student Info & Emergency Contacts & Emergency Consents & Health Insurance	A. **Student Information** B. **Emergency Contacts** C. **Emergency Consents: If you (the student) are under 18 years of age, prior to your arrival on campus,** your parent/guardian must sign this section. D. **Health Insurance:** Here are some key terms that you'll come across when filling out health insurance forms: i. **Subscriber:** The subscriber is the person who is the main policyholder or who holds the health insurance plan. If your parents are covering you on their insurance, your parent is the subscriber. If you're getting insurance through your own job, school, or MassHealth, then you would be listed as the subscriber. ii. **Member ID Number:** This is the unique number assigned to your insurance plan. You will need this to confirm coverage and file claims. iii. **Group Name & Number**: This name and number identify the specific health insurance plan provided by the employer or organization to its members. It helps insurance companies quickly locate the details of the plan for claims processing, benefits, and coverage verification. Your insurance card may or may not list this information. iv. In addition, please upload a **front and back copy of your health insurance card**.
	Page 2: Immunizations	A. **Immunizations**: Your clinician does not have to complete the Regis Immunizations Form if you can upload an official medical record of your immunizations. This record must include the following: 1. Hepatitis B 2. Meningococcal Vaccination or Waiver Forms 3. MMR (Measles [Rubeola], Mumps, Rubella) 4. Tdap (Tetanus, Diphtheria, Pertussis) 5. Varicella (Chicken Pox)
	Page 3: TB Questionnaire & Testing Forms	A. **TB Questionnaire:** Please refer to detailed instructions on the TB Questionnaire.
If you have any questions or concerns, please do not hesitate to contact the Regis College Center for Health and Wellness at 781-768-7290 or by email at healthcompliance@regiscollege.edu		

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Student Health Forms Today's Date: _____/_____/_____

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

STUDENT INFORMATION & EMERGENCY CONSENTS & HEALTH INSURANCE INFORMATION

STUDENT INFORMATION

Name of Student:_____ Regis ID #:_____
last first middle

Date of Birth: _____/_____/_____ Sex Assigned at Birth: _____ Place of Birth:_____
month day year Country

Permanent Street Address: _____

City: _____ State: _____ Zip Code: _____

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

Regis Email: _____

EMERGENCY CONTACTS

Name:_____ Relationship to Student:_____
last first middle

Permanent Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: (_____)_____ Business: (_____)_____ Cell: (_____)_____

Name:_____ Relationship to Student:_____
last first middle

Permanent Street Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Numbers: Home: (_____)_____ Business: (_____)_____ Cell: (_____)_____

EMERGENCY CONSENTS

In the event of a medical or mental health emergency on campus, I authorize Regis College staff to arrange emergency transport to a medical facility if deemed necessary. I further authorize the Regis College Center for Health and Wellness to share relevant information regarding my emergency medical condition with the emergency medical personnel and necessary Regis College staff. I understand that, if transported to an emergency facility, I may be required to provide clearance documentation upon my return to campus. If I am unable to provide this documentation, I understand that I will be required to obtain clearance by a Nurse Practitioner or Counselor at the Regis College Center for Health and Wellness to assess my fitness to safely return to campus activities. I understand that by typing my signature below, it serves as an electronic signature.

Student Name:_____ Date: _____/_____/_____
last first middle month day year

Student Signature:_____

TO BE SIGNED BY PARENT OR GUARDIAN, IF STUDENT IS UNDER THE AGE OF 18

Name:_____ Date: _____/_____/_____
last first middle month day year

HEALTH INSURANCE INFORMATION: Please upload a front and back image of the student's insurance card.

Health Insurance Company:	Health Insurance Address:
Health Insurance Group Name:	Health Insurance Phone Number:
Member ID#	Group #:
Subscriber's Name : Subscriber's D.O.B: _____/_____/_____	Subscriber's Relationship to Insured:

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Student Health Forms Today's Date: _____/_____/_____

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

IMMUNIZATIONS

You do not need to have your clinician fill this form if you can upload an official medical record of your immunizations.

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 **1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger.**	**Vaccine Name:** _____ Single Dose:___/___/___ **OR Signed Waiver (Link to waiver is below):**_____ https://www.mass.gov/doc/information-about-meningococcal-disease-meningococcal-vaccines-vaccination-requirements-and-the-waiver-for-students-at-colleges-and-residential-schools	**1 dose;** The dose of MenACWY vaccine must have been received on or **after the student's 16th birthday. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided in this packet**. Meninococcal 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:___/___/___	Vaccine for the current flu season
Meningococcal Group B **MenB-4C (Bexsero)** **OR** **MenB-Fhbp (Trumenba)**	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ #3___/___/___	Bexsero: 2 doses at least one month apart Trumenba: 3 doses at 0, 3 and 6 month intervals
Human Papillomavirus (HPV)	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #3___/___/___	3 doses at 0, 3 and 6 month intervals
Hepatitis A **OR** **Hepatitis A & B Combined**	**Vaccine Name:**_____ #1___/___/___ #2___/___/___ #1___/___/___ #2___/___/___ #3___/___/___	Hepatitis A: 2 doses at least 6 months apart Hepatitis A & B Combined: 3 doses given at 0, 3 and 6 month intervals.
COVID-19 Vaccines:	**Vaccine Name:** _____ Date: ___/___/___ **Vaccine Name:** _____ Date: ___/___/___ **Vaccine Name:** _____ Date: ___/___/___ **Vaccine Name:** _____ Date: ___/___/___	COVID-19 vaccines per CDC recommendations.

HEALTHCARE PROVIDER'S SIGNATURE:

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

Address: (Including City and State):_____ Phone #: ( ) _____

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Student Health Forms Today's Date: _____/_____/_____

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

TUBERCULOSIS (TB) QUESTIONNAIRE AND TESTING FORM

Country of Birth: _____ **Year Arrived in the US:** _____

	PART 1: HISTORY OF TUBERCULOSIS: TO BE COMPLETED BY INCOMING STUDENT/PARENT/GUARDIAN	YES	NO
#1	Have you ever been sick with Tuberculosis (TB) ***If yes, when***:_____		
#2	Have you ever had a positive PPD, TB Quantiferon test, or T-Spot? ***If yes, when***:_____		
	PART 2: AT RISK FOR TUBERCULOSIS: TO BE COMPLETED BY INCOMING STUDENT/PARENT/GUARDIAN		
#3	Have you ever had close contact with persons known or suspected to have active TB disease? If yes, when? _____		
#4	Were you born in, or have you lived, worked or visited for more than one month in any of the following: Asia, Africa, South America, Central America, or Eastern Europe? a. If yes, what country? _____ How long? _____ b. Reason: ϒ Born there ϒ Tourist ϒ Work ϒ School ϒ Other		
#5	Have you been a resident, volunteer and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities and/or homeless shelter?		
#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 ever been a member of any of the following groups that may have an increased incidence of inactive TB infection or active TB disease: medically underserved, low-income, or using drugs or alcohol?		

- **If the answer to ALL of the questions above is NO, SKIP** the remaining sections of this form. (No Health Care Provider Signature needed.)
- **If the answer is YES to question 1 or 2 above, no additional TB testing (TST, IGRA) should be performed. HOWEVER, your healthcare provider must complete PARTS 3, 4, and 5 with documentation as needed.**
- **If the answer is YES to any of the questions 3-7 above**, Regis College requires that you receive ***TB testing within the last six months prior to the start of the program***. **Your healthcare provider must complete PARTS 3, 4 and 5 with additional documentation as needed.**

PART 3: TB TESTING: 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: _____/_____/_____ Date Read: _____/_____/_____ Result: # of mm of induration:_____

- **QUANTIFERON-TB GOLD OR T-SPOT:**

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.

- **CHEST X-RAY:**

Date of Chest x-ray: _____/_____/_____ Result: ☐ Abnormal ☐ Normal Interpretation:_____

Please attach a copy of the written chest x-ray report

	PART 4: 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? If the patient declined treatment, please provide most recent TB symptom review. ***Those 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.***		
#3	Did the patient agree to receive treatment at this time? • Indicate medication(s) prescribed: Start Date: _____/_____/_____ End Date: _____/_____/_____ _____		

PART 5: SIGNATURE OF HEALTH CARE PROVIDER

Signature of Health Care Provider Printed Name Date

Mailing Address Office Phone Office Fax Number