



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. 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.

If you have noted a medical condition, chronic illness, or significant allergy on your health forms, we recommend reaching out to the Regis College Center for Health and Wellness at 781-768-7290 to schedule a complimentary consultation with one of our healthcare providers. They can help discuss how we can best assist you.

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

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	<p>A. Student Information</p> <p>B. Emergency Contacts</p> <p>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.</p> <p>D. Health Insurance: Here are some key terms that you'll come across when filling out health insurance forms:</p> <p>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.</p> <p>ii. Member ID Number: This is the unique number assigned to your insurance plan. You will need this to confirm coverage and file claims.</p> <p>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.</p> <p>iv. In addition, please upload a front and back copy of your health insurance card.</p>
	Page 2: Health History	<p>A. Medical Condition/Chronic Illness/Allergies: If you have indicated that you have a medical condition, chronic illness or a concerning allergy, we encourage you to contact the Regis Center for Health and Wellness at: 781-768-7290 to schedule a free consultation with one of our clinicians to discuss how they may be of assistance to you.</p>
	Page 3: Immunizations	<p>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:</p> <ol style="list-style-type: none"> 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 4: TB Questionnaire & Testing Forms	<p>A. TB Questionnaire: Please refer to detailed instructions on the TB Questionnaire.</p>

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



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

HEALTH HISTORY FORM

STUDENT MEDICAL HISTORY

Health Issues: please check all that apply:

- | | | | | |
|-------------------------------------|--|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Ear | <input type="checkbox"/> Liver | <input type="checkbox"/> Rubella | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Measles | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Eye | <input type="checkbox"/> Mental Health | <input type="checkbox"/> Sickle Cell | |
| <input type="checkbox"/> COVID-19 | <input type="checkbox"/> Heart | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid | |

If you have checked off any of the above, or there is additional information on the youth's physical health, please provide details below or add additional papers/documents.

Comments:

Please check all that apply:

What type of diet are you following?

- | | | |
|-------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Vegetarian | <input type="checkbox"/> Gluten Free | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Diabetic | _____ |

Are you currently followed by a medical provider for a medical condition?	Yes	No
Reason(s):		
Are you currently followed by a medical provider for a mental health condition?	Yes	No
Reason(s):		
Have you had any surgical procedures?	Yes	No
If yes, list with dates:		
ALLERGIES		
Do you have any allergies? If so, please specify below, including the reaction.	Yes	No
Medication(s)/Reaction:		
Food(s)/Reaction:		
Other(s)/Reaction:		
Do you carry an Epi-Pen? If yes, the student must arrive with two.	Yes	No

If you have indicated that you have a **medical condition, chronic illness or a concerning allergy**, we encourage you to contact the Regis Center for Health and Wellness at: 781-768-7290 to schedule a free consultation with one of our clinicians to discuss how they may be of assistance to you.



REGIS

CENTER FOR HEALTH
AND WELLNESS

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: <ul style="list-style-type: none"> • 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 1 st 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 1 st 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.
<u>STRONGLY RECOMMENDED & ADDITIONAL IMMUNIZATIONS</u>	<u>Dates Received</u>	<u>Standing Dosing</u>
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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CENTER FOR HEALTH
AND WELLNESS

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) <i>If yes, when:</i> _____		
#2	Have you ever had a positive PPD, TB Quantiferon test, or T-Spot? <i>If yes, when:</i> _____		
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? <i>If yes, when:</i> _____		
#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: <input type="checkbox"/> Born there <input type="checkbox"/> Tourist <input type="checkbox"/> Work <input type="checkbox"/> School <input type="checkbox"/> 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 shelters)?		
#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 6 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