Dear Incoming Regis Student:

The Regis College Center for Health and Wellness would like to welcome you to Regis. Regis College and Massachusetts law and Regis College requires that all incoming students provide proof of immunizations, have a physical examination prior to their arrival on campus, and submit their health forms. **Students must complete the downloaded health forms and upload completed medical documentation through CastleBranch** (see next page for step-by-step instructions). Regis athletes must complete this process in addition to the athletic department requirements.

**Due Dates:**
All health records are required by:
- July 31, 2022 for fall enrollment
- January 2, 2023 for spring enrollment

Students must provide all required health records, including vaccination records, by the stated deadline. Failure to comply with that deadline could result in consequences which may include but are not limited to, removing you from your current courses, restricting your access to Moodle, and/or preventing you from registering for future courses. **Students 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. 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 students are properly insured to meet the state law, all students are initially charged on their student account for the cost of the Blue Cross Blue Shield 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. If you have any questions regarding health insurance, please call the Regis Center for Student Services at 781-768-7270.

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

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

Sincerely,

Tammi Magazzu

Tammi Magazzu, RN, WHNP-BC
Associate Dean and Medical Director of 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. Your Personal Identification Number (PIN) is your student ID number
6. Enter your Regis email address (which will then become your myCB username) along with the required personal information to complete your order.

Log into CastleBranch and Download the required forms for printing:
Regis Health Services Forms can be downloaded from Clinical Requirements, menu Option #1 (Regis Health Services Forms). You must click on the blue link.

Uploading required documentation:
The most effective way to upload your document to CastleBranch is to scan it, save it as a PDF and upload the PDF to the requirement. However, if you don’t have access to a scanner but have an Apple product, you can download the free myCB from the App store to upload your documents. Please note: if you upload a picture using the myCB app, the photo must be taken in portrait not landscape orientation (meaning your phone is held vertically) and be clear and legible, and meet the clinical requirement or it will be rejected.

1. Regis Health Services Forms: Student must complete both forms. Upload Health Report Part 1 and 3 together. Do not upload them separately.

2. Health Form and Health Insurance: Student must complete this form Upload Health Report Part 2 and a copy (front and back) of your health insurance card together. Do not upload them separately.

3. Physical Exam: Upload a recent (within 1 year) physical exam signed by a doctor. You may use our physical exam form from our packet or a pre-printed document from your doctor. If you use an electronic document from your doctor, make sure it has an electronic signature.

4-9. Immunizations: You may use our immunization form or a pre-printed form from your provider. If you are using our immunization form, it must be signed by a doctor. If you are using a provider’s pre-printed form, make sure your name and the facility name appear on the document. Important: Upload your entire immunization record for each vaccine.

MMR (Measles (Rubeola), Mumps, Rubella): Upload documentation of two MMR vaccines or positive titers with lab results.

Varicella (Chicken Pox): Upload documentation of two varicella vaccines or a positive titer with lab results or medical documentation of disease.

Hepatitis B: Upload documentation of hepatitis B or hepatitis A/B vaccines or a positive hepatitis B titer with lab results.

Tdap (Tetanus, Diphtheria, Pertussis): Upload documentation of DTaP primary series, Tdap booster and Td booster.
Meningococcal Vaccination or Waiver (required for all full-time students under age 22): 1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger. Upload proof of one dose of MenACWY vaccine received on or after the student’s 16th birthday (use the same vaccination record if it includes all vaccinations) or upload the Meningococcal Waiver provided in the health forms that you have signed, dated and have checked the box stating you reviewed the materials. A parent/guardian must complete this for students under 18.

COVID-19 Vaccine: Required for all students (regardless of age) to have received all doses of COVID-19 vaccine in the primary series and one booster dose, when eligible.

Options to meet this requirement:

- 2 Pfizer vaccinations, **OR**
- 2 Moderna vaccinations, **OR**
- 1 Janssen (Johnson & Johnson) vaccination, **OR**
- COVID vaccines that have received Emergency Use Authorization (EUA) by the FDA, **OR**
- COVID vaccines that have received Emergency Use Listing (EUL) from the WHO, **AND**
- Booster (Pfizer or Moderna) 2 months after Johnson & Johnson vaccination, **OR**
- Booster (Pfizer or Moderna) 5 months after second dose of Pfizer or Moderna vaccination

10. Tuberculosis (TB): Complete the Tuberculosis Risk Questionnaire. Please include your name, date of birth, country of birth, and the date that you complete the questionnaire. If you answer NO to all TB questionnaire questions, upload the questionnaire only. If you answer YES to any of the questions on the Tuberculosis Risk Questionnaire, you are required to have TB testing and have a healthcare provider fill out the Medical Evaluation for latent TB. Upload the TB Questionnaire and the Medical Evaluation for latent TB together along with all applicable TB forms. Regis requires that you receive TB testing within 6 months prior to the start of the semester that you are entering school.

Once you have uploaded the required forms for all above requirements, the status for each line item will be **PENDING REVIEW**. CastleBranch personnel will review each line item to ensure that you have the appropriate information. If the information meets the requirements, the status for the line item will be changed to **COMPLETE**. If it does not meet the requirement, the status will be **REJECTED** and the reason for the rejection will be listed. To upload the corrected information for any line item you must re-upload ALL pages for that particular CastleBranch section. For example, if you did not complete all of the information on Health Report #2 it will be rejected. Once you correct the form you must upload the Health Report #2 **AND** a copy of the front and back of your medical insurance card again. If you have any questions, please call Regis College Center for Health and Wellness 781-768-7290 or email Health Services at health.services@regiscollege.edu. For technical support you can also contact the CastleBranch service desk directly at 888-723-4263.
To be filled out by student in its entirety

Name: ___________________________________________ Date of Birth: ______/______/______

Last First MI Month Day Year

Permanent Address: _______________________________________________________

Street ________________________________________________ _______ ________

City State Zip Country

Birthplace (country): __________________________

Home Telephone: (_____) ___________________ Student Cell: (_____) _____________________

Regis Student ID#: ____________________________

Resident _____ Commuter_____

Email: __________________________________________

Regis Athlete: No ____ Yes ____ Sport: ____________

Date entering Regis: ________________________

Expected Date of Graduation: __________________

Status: Undergraduate _____ Graduate _____

Nursing/Health Science student _____

Father’s Name: ________________________________

Mother’s Name: ______________________________

Father’s daytime phone: (_____) __________________

Mother’s daytime 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: ________________________
**REGIS COLLEGE HEALTH REPORT Part 2**

### PRIMARY HEALTH INSURANCE INFORMATION

<table>
<thead>
<tr>
<th>Information</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Company name:</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Insurance address:</td>
<td>______________________________________</td>
</tr>
<tr>
<td>Insurance phone number:</td>
<td>_________________________________</td>
</tr>
<tr>
<td>Group name:</td>
<td>______________________________________</td>
</tr>
<tr>
<td>ID#:</td>
<td>___________________________ Group#:</td>
</tr>
<tr>
<td>Name of Subscriber:</td>
<td>_____________________________________</td>
</tr>
<tr>
<td>Subscriber DOB:</td>
<td>____________________ Relationship to insured:</td>
</tr>
<tr>
<td>Primary care physician:</td>
<td>____________________________ Physician phone number:</td>
</tr>
</tbody>
</table>

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 is NOT a waiver for the Regis student health insurance.*

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### MASSACHUSETTS IMMUNIZATION INFORMATION SYSTEMS

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 healthcare provider’s information will be entered to identify you within 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 healthcare providers who use MIIS, please complete the MIIS Objection Form (mass.gov/eohhs/docs/dph/cdc/immunization/miis-objection-form.pdf)

Student Name: ____________________________________    Date of Birth: ___________________

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### 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 the above named 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 signature (Required) ________________________  Date______  Parent/guardian signature  _______________________   Date_______

(Parent/guardian 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, Regis College discloses individual health information to certain partners and government agencies. Specifically, Regis discloses health information to entities that operate systems or software programs (e.g. CoVerified) that enable Regis to monitor concerning symptoms, health testing, and vaccinations across the community. By signing below, I grant Regis permission to make these disclosures.

Student signature (Required) ________________________  Date______  Parent/guardian signature  _______________________   Date_______

(Parent/guardian signature required for all students under the age of 18)
### 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>Neuromuscular 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 indicate date)

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
<th>Date</th>
<th>Medical Diagnosis</th>
<th>Date</th>
<th>Medical Diagnosis</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal Pap Smear</td>
<td></td>
<td>Heart murmur/click</td>
<td></td>
<td>Pneumothorax</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td></td>
<td>Heart disease/problem</td>
<td></td>
<td>Psychological problem</td>
<td></td>
</tr>
<tr>
<td>Anorexia</td>
<td></td>
<td>Hepatitis</td>
<td></td>
<td>Positive TB test</td>
<td></td>
</tr>
<tr>
<td>Anxiety disorder</td>
<td></td>
<td>High blood pressure</td>
<td></td>
<td>Rheumatic fever</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
<td>HIV infection/disease</td>
<td></td>
<td>Seizure disorder</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Impaired mobility</td>
<td></td>
<td>Sickle cell disease</td>
<td></td>
</tr>
<tr>
<td>Bulimia</td>
<td></td>
<td>Kidney stone</td>
<td></td>
<td>Testicular disease/problem</td>
<td></td>
</tr>
<tr>
<td>Cancer/malignancy</td>
<td></td>
<td>Learning disability</td>
<td></td>
<td>Thyroid problem</td>
<td></td>
</tr>
<tr>
<td>Chickenpox</td>
<td></td>
<td>Malaria</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Colitis/ileitis</td>
<td></td>
<td>Migraines</td>
<td></td>
<td>Ulcer/stomach problem</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Mononucleosis</td>
<td></td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td>Neurologic problem</td>
<td></td>
<td>Other:</td>
<td></td>
</tr>
<tr>
<td>Gynecological problem</td>
<td></td>
<td>Phlebitis/deep vein clot</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polycystic Ovary Syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### GYNECOLOGICAL HISTORY:

Age of onset of menses:      Length of cycle:      Date of Last Pap smear:      Result:      

Have you ever had an abnormal Pap smear?      Have you ever had a colposcopy?      Date & Result:      

<table>
<thead>
<tr>
<th>Medical Diagnosis</th>
<th>Date</th>
<th>Medical Diagnosis</th>
<th>Date</th>
<th>Medical Diagnosis</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular periods</td>
<td></td>
<td>Breast lumps/</td>
<td></td>
<td>Sexually transmitted disease</td>
<td></td>
</tr>
<tr>
<td>No periods</td>
<td></td>
<td>fibrocystic disease</td>
<td></td>
<td>Use contraception</td>
<td></td>
</tr>
<tr>
<td>Painful cramps</td>
<td></td>
<td>Pelvic Inflammatory disease</td>
<td></td>
<td>Pregnancy (live births)#</td>
<td></td>
</tr>
<tr>
<td>Bleeding between periods</td>
<td></td>
<td></td>
<td></td>
<td>Abortion/miscarriage #:</td>
<td></td>
</tr>
<tr>
<td>Polycystic Ovary Syndrome</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

### MEDICATIONS: Please list all prescription and over-the-counter medications, including birth control, supplements, etc.:

### ALLERGIES:  Yes or No. If yes, please specify including medications, insect, food, etc.:

### Please answer questions below and circle your response.

1. Do you exercise? Never, Occasionally, 3-5 times/week weekly
2. Do you wear a seatbelt? Always, Sometimes, Never
3. Do you follow any diets? No, Yes, If yes, what kind?
4. Are you concerned about your eating habits? No, Yes
5. Would you describe your weight as?: Underweight, Just right, Overweight
6. Do you smoke cigarettes? No, Yes, How many per day?
7. Do you now or have you ever used recreational drugs? No, Yes, which one(s)?
8. Do you drink alcohol? No, Yes, If yes, how often?
9. When you drink, how many do you usually have?
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 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: / / 

Height: ___________ Weight: ___________ BMI: __________ BP: __________ Pulse: ________

<table>
<thead>
<tr>
<th>System</th>
<th>Normal</th>
<th>Describe Abnormality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. HEENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Lungs/Chest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Breasts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Heart/Vascular System</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Abdomen (rectal if indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Genito-urinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Gynecological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Lymphatic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Neurological</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Psychological</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 (all prescription and OTC): __________________________

Applicant may participate in school/sports/activities: _____ without restriction/limitation; _____ with the following restriction/limitation __________________________; _____ should not participate in school/sports/activities. Reason(s) for restricting participation: __________________________

HEALTH CARE PROVIDER
Name (please print) __________________________ Signature __________________________

Address __________________________ Phone (_____) __________ Fax (_____) __________
If you have chosen to use this immunization form, it must be completed and signed by your health care provider.

### Required Vaccines

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>Dates Received</th>
<th>MA State Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong>  (may be Hepatitis B OR Hepatitis A/B combined)</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>3 doses; laboratory evidence of immunity acceptable; 2 doses of Heplisav-B given on or after 18 years of age are acceptable.</td>
</tr>
<tr>
<td>#3/<em><strong>/</strong></em></td>
<td>OR Positive Titer HBsAB Date: / / (copy of lab result required)</td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal Quadrivalent</strong>  1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger.</td>
<td>Single Dose: / / OR Signed Waiver:</td>
<td>1 dose; The dose of MenACWY vaccine must have been received on or after the student’s 16th birthday or Signed Waiver.</td>
</tr>
<tr>
<td><strong>MMR (Measles, Mumps, Rubella)</strong>  OR individual vaccines or titers:</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>2 doses; first dose must be given on or after the 1st birthday and second dose must be given &gt;28 days after first dose; laboratory evidence of immunity acceptable.</td>
</tr>
<tr>
<td>• Measles</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td></td>
</tr>
<tr>
<td>• Mumps</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>OR Positive Titer Date: / / (copy of lab results required)</td>
</tr>
<tr>
<td>• Rubella</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>OR Positive Titer Date: / / (copy of lab results required)</td>
</tr>
<tr>
<td><strong>Tdap (Tetanus, Diptheria, Pertussis)</strong></td>
<td>Tdap: / /</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Varicella</strong></td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>2 doses; first dose must be given on or after the 1st birthday and second dose must be given &gt;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.</td>
</tr>
<tr>
<td>OR Individual Vaccines or Titers:</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COVID-19 Vaccine</strong></td>
<td>Vaccine Name:</td>
<td>• Janssen (Johnson &amp; Johnson) 1 dose only</td>
</tr>
<tr>
<td>Single Dose: / /</td>
<td>• Pfizer-BioNTech: 2 doses, 21 days apart</td>
<td></td>
</tr>
<tr>
<td>Two Dose: #1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>• Moderna: 2 doses, 28 days apart</td>
<td></td>
</tr>
<tr>
<td><strong>COVID-19 Booster</strong></td>
<td>Vaccine Name:</td>
<td>• Other: with WHO EUL or FDA EUA</td>
</tr>
<tr>
<td>Dose Date: / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Influenza</strong>  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
<td>Vaccine Name:</td>
<td>Single dose for 2022-2023 influenza season</td>
</tr>
<tr>
<td>Single Dose: / /</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal Group B</strong>  MenB-4C (Bexsero)  OR  MenB-Fhbp (Trumenba)  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
<td>Vaccine Name:</td>
<td>Bexsero: 2 doses at least one month apart</td>
</tr>
<tr>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>Trumenba: 3 doses at 0, 3 and 6 month intervals</td>
<td></td>
</tr>
<tr>
<td>#3/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV)</strong>  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
<td>Vaccine Name:</td>
<td>3 doses at 0, 3 and 6 month intervals</td>
</tr>
<tr>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#3/ /</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A</strong>  OR  <strong>Hepatitis A &amp; B Combined</strong></td>
<td>Vaccine Name:</td>
<td>Hepatitis A: 2 doses at least 6 months apart</td>
</tr>
<tr>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
<td>Hepatitis A &amp; B Combined: 3 doses given at 0, 3 and 6 month intervals.</td>
<td></td>
</tr>
<tr>
<td>#3/ /</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### STRONGLY RECOMMENDED & ADDITIONAL IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>Dates Received</th>
<th>Standing Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Influenza</strong>  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
<td>Single Dose: / /</td>
<td>Single dose for 2022-2023 influenza season</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal Group B</strong>  MenB-4C (Bexsero)  OR  MenB-Fhbp (Trumenba)  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
<td>Vaccine Name:</td>
<td>Bexsero: 2 doses at least one month apart</td>
</tr>
<tr>
<td></td>
<td>Trumenba: 3 doses at 0, 3 and 6 month intervals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em></td>
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</tr>
<tr>
<td><strong>Human Papillomavirus (HPV)</strong>  <em>THIS VACCINE IS STRONGLY RECOMMENDED</em></td>
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<tr>
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<td>Vaccine Name:</td>
<td>Hepatitis A: 2 doses at least 6 months apart</td>
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<tr>
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<td>#3/ /</td>
<td></td>
</tr>
</tbody>
</table>

Clinician’s Name (Please Print):_______________________________ Signature:____________________________________ Date:______________

Address: (Including City and State):___________________________________________________________________________________________

Phone: (_____)_____________________________________  Fax:(_____)_____________________________
REQUIRED for all undergraduate students to complete

Student’s Name: _________________________________   Date of Birth: ___/____/____ Today’s date: ___/____/____

Country of Birth: _________________________

Tuberculosis (TB) Screening Questionnaire (to be completed by incoming students)

Please answer the following questions:

Have you ever tested positive for Tuberculosis?  
☐ Yes  ☐ No

Have you ever had close contact with persons known or suspected to have active TB disease?  
☐ Yes  ☐ No

Were you born in one of the countries or territories listed below that have a high incidence of active TB disease? (If yes, please CIRCLE the country, below)

☐ Yes  ☐ No

Afghanistan  Comoros  India  Indonesia  Myanmar
Algeria  Congo  Congo  Iraq  Namibia
Angola  Côte d’Ivoire  Democratic People’s Republic of Korea  Kazakhstan  Nauru
Argentina  Armenia  Azerbaijan  Kenya  Nepal
Azerbaijan  Bangladesh  Barbados  Kiribati  Nicaragua
Belgium  Belize  Benin  Kuwait  Niger
Benin  Bhutan  Botswana  Kyrgyzstan  Nigeria
Bolivia  (Plurinational State of)  Brazil  Lao People’s Democratic Republic  Niue
Bosnia and Herzegovina  Brunei Darussalam  Bulgaria  Latvia  Northern Mariana Islands
Botswana  Burkina Faso  Burundi  Lesotho  Pakistan
Brazil  Cabo Verde  Cambodia  Liberia  Palau
Bhutan  Cameroon  Central African Republic  Libya  Papua New Guinea
Bolivia  Chad  China  Madagascar  Paraguay
Botswana  China, Hong Kong SAR  Chadian  Malawi  Peru
Central African Republic  Chad  China, Macao SAR  Malaysia  Philippines
Chad  China  Colombia  Maldives  Qatar
Central African Republic  Chad  Colombia  Mali  Russian Federation
Chad  China  Colombia  Marshall Islands  Rwanda
China  Comoros  Central African Republic  Mauritania  Sao Tome and Principe
China, Hong Kong SAR  Comoros  Chad  Mexico  Senegal
China, Macao SAR  Congo  Chadian  Micronesia (Federated States of)  Sierra Leone
Colombia  Democratic People’s Republic of Korea  Democratic Republic of the Congo  Mongolia  Singapore


Have you had frequent or prolonged visits* to one or more of the countries or territories listed above with a high prevalence of TB disease? (If yes, CHECK the countries or territories, above)

☐ Yes  ☐ No

Have you been a resident and/or employee of high-risk congregate settings (e.g., correctional facilities, long-term care facilities, and homeless shelters)?  
☐ Yes  ☐ No

Have you been a volunteer or health care worker who served clients who are at increased risk for active TB disease?  
☐ Yes  ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease: medically underserved, low-income, or abusing drugs or alcohol?

☐ Yes  ☐ No

If you answer YES to any of the above questions, Regis College requires that you receive TB testing within 6 months prior to the start of the semester. Your healthcare provider must complete the Medical Evaluation for Latent TB Infection Form. All applicable TB forms must be submitted together.

If the answer to all of the above questions is NO, no further testing or further action is required.

*The significance of the travel exposure should be discussed with a health care provider and evaluated.
Regis College
Medical Evaluation for TB Infection

(To be completed by a healthcare professional)
This form is required if the TB Risk Questionnaire has a YES response.
Please refer to Tuberculosis Risk Questionnaire form before completing.

Student's Name: ___________________________ Date of Birth: _____/_____/____ Country of Birth: ____________

STEP 1: Tuberculin Skin Test (TST)-Must be performed within 6 months before start of semester. If this test has previously resulted "positive"
OR patient has received BCG vaccine, skip to Step 2.

1. Tuberculin Skin Test (TST) - Please note: TST result should be recorded as actual millimeters (mm) of induration, transverse
diameter; if no induration, write "0". The TST should be based on mm of induration as well as risk factors.)**

Date administered: ____/____/____
Date test read: ____/____/____
Result: ____mm of induration

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 jejunooileal
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.

STEP 2: If POSITIVE Tuberculin Skin Test or history of BCG vaccination), Blood Testing for Tuberculosis is required:

Method used: (please check one) _____QFT-G _____ T-spot other_________ Date obtained: ____/____/____

**Please attach a copy of the lab report.
Result: (Please check one) ___Negative ___ Positive ___ Intermediate ___ Borderline_______ (T-Spot only)

STEP 3: If POSITIVE IGRA Result in Step 2, a Chest X-Ray is required:
(Mantoux / Intermediate PPD or IGRA tests)

1. Date of POSITIVE test: ____/____/____ Testing method: (please check one) _____ Mantoux /PPD _____ IGRA

2. Chest X-Ray: (please check one) _____Normal _____ Abnormal Please attach a copy of the report (no discs or films)
Describe: ____________________________________________________________________________________

3. Clinical Evaluation: Does the student have signs or symptoms of active pulmonary tuberculosis disease?

(please check one) ____Yes ____No
Describe: ____________________________________________________________________________________

4. Treatment: (please check one) ____Yes ____No

Describe: ____________________________________________________________________________________

Healthcare provider signature: (Required)_________________________________________ Date: ______/_____/________

Healthcare Provider Name (Please print): ______________________________________ Phone: (______)_____________________

Revised: 6/14/2022 3:20 PM
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 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).

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 of Regis College Center for Health and Wellness
What is meningococcal disease?
Meningococcal disease is caused by infection with bacteria called Neisseria meningitidis. These bacteria can infect the tissue that surrounds the brain and spinal cord called the “meninges” and cause meningitis, or they can infect the blood or other body organs. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, sensitivity to light and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. Less common presentations include pneumonia and arthritis. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 10-20% lose their arms or legs, become hard of hearing or deaf, have problems with their nervous systems, including long term neurologic problems, or suffer seizures or strokes.

How is meningococcal disease spread?
These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?
High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists who work with the organism and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as first year college students living on campus and military recruits are also at greater risk of disease from some of the serogroups.

Which students are most at risk for meningococcal disease?
In the 1990s, college freshmen living in residence halls were identified as being at increased risk for meningococcal disease. Meningococcal disease and outbreaks in young adults were primarily due to serogroup C. However, following many years of routine vaccination of young people with quadrivalent meningococcal conjugate vaccine (for serogroups A, C, W and Y), serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Among the approximately 9 million students aged 18-21 years enrolled in college, there are an average of 20 cases and 0-4 outbreaks due to serogroup B reported annually. Although incidence of serogroup B meningococcal disease in college students is low, four-year college students are at increased risk compared to non-college students; risk is highest among first-year students living on campus. The close contact in college residence halls, combined with social mixing activities (such as going to bars, clubs or parties; participating in Greek life; sharing food or beverages; and other activities involving the exchange of saliva), may put college students at increased risk.

Is there a vaccine against meningococcal disease?
Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menevo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease. Quadrivalent meningococcal conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. Students receiving their first dose on or after their 16th birthday do not need a booster. Individuals in certain high risk groups may need to receive 1 or more of these vaccines based on their doctor’s recommendations. Adolescents and young adults (16-23 years of age) who are not in high risk groups may be vaccinated with meningococcal B vaccine, preferably at 16-18 years of age, to provide short-term protection for most strains of serogroup B meningococcal disease. Talk with your doctor about which vaccines you should receive.
Is the meningococcal vaccine safe?
Yes. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women. A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions, but these are rare.

Is meningococcal vaccine mandatory for entry into secondary schools that provide housing, and colleges?
Massachusetts law (MGL Ch. 76, s.15D) and regulations (105 CMR 220.000) requires both newly enrolled full-time students attending a secondary school (those schools with grades 9-12) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution and newly enrolled full-time students 21 years of age and younger attending a postsecondary institution (e.g., colleges) to receive a dose of quadrivalent meningococcal conjugate vaccine.

At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. Secondary school students must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine at any time in the past, unless they qualify for one of the exemptions allowed by the law. College students 21 years of age and younger must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday, regardless of housing status, unless they qualify for one of the exemptions allowed by the law. Meningococcal B vaccines are not required and do not fulfill the requirement for receipt of meningococcal vaccine. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Exemptions: 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 can’t receive the vaccine; 2) the student (or the student’s parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student’s parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided and elected to decline the vaccine.

Shouldn’t meningococcal B vaccine be required?
CDC’s Advisory Committee on Immunization Practices has reviewed the available data regarding serogroup B meningococcal disease and the vaccines. At the current time, there is no routine recommendation and no statewide requirement for meningococcal B vaccination before going to college (although some colleges might decide to have such a requirement). As noted previously, adolescents and young adults (16 through 23 years of age) may be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection against most strains of serogroup B meningococcal disease. This would be a decision between a patient or parent and a healthcare provider. These policies may change as new information becomes available.

Where can a student get vaccinated?
Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of these vaccines. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?
- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and www.mass.gov/dph/epi
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement
I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of quadrivalent meningococcal conjugate vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school, and newly enrolled full-time students at colleges and universities who are 21 years of age or younger to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

☐ After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name: __________________________ Date of Birth: ________ Student ID: ________
Signature: __________________________ Date: __________

(Student or parent/legal guardian, if student is under 18 years of age)
YOUR MEDICAL RECORD

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

Your medical record is the property of Regis College Center for Health and Wellness. 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 Regis staff and/or faculty 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 may take up to 7 business days to process. There will be a $25.00 administrative processing fee for each request. We appreciate as much notice as possible.