Dear Incoming Student:

The Regis College Center for Health and Wellness would like to welcome you to Regis. Regis College and Massachusetts law requires that all incoming students provide proof of immunizations 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 any additional 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)
4. Accept the Terms and Conditions of Use and select Continue
5. 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.

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.

3-7. 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.
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

8. 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 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: (_____) __________________          Daytime phone: (_____) __________________

Evening phone: (_____) __________________          Evening phone: (_____) __________________

Relationship to student: __________________________

ALTERNATE EMERGENCY CONTACT:

Name: __________________________          Address: __________________________

Daytime phone: (_____) __________________          Daytime phone: (_____) __________________

Evening phone: (_____) __________________          Evening phone: (_____) __________________

Relationship to student: __________________________
### PRIMARY HEALTH INSURANCE INFORMATION

Insurance Company name: _______________________________________
Insurance address: _____________________________________________
Insurance phone number: _________________________________
Group name: _______________________________________________
ID#:_________________________ Group#:_________________________
Name of Subscriber: _______________________________________
Subscriber DOB: ____________________ Relationship to insured: ______________________
Primary care physician: ____________________ Physician phone number: ______________________

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.*

### 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 designed 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 the 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: ___________________

### 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______

(Owner/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______

(Owner/guardian signature required for all students under the age of 18)
# REGIS COLLEGE CENTER FOR HEALTH AND WELLNESS IMMUNIZATIONS FORM

If you have chosen to use this immunization form, it must be completed and signed by your health care provider.

<table>
<thead>
<tr>
<th>Required Vaccines</th>
<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></td>
<td></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><strong>Meningococcal Quadriivalent</strong></td>
<td></td>
<td></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></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Measles</td>
<td>#1/<em><strong>/</strong></em> #2/<em><strong>/</strong></em> #3/<em><strong>/</strong></em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td><em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___ <em><strong>/</strong></em>/___</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tdap (Tetanus, Diphtheria, Pertussis)</strong></td>
<td>Tdap: <em><strong>/</strong></em>/___</td>
<td></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></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td><strong>COVID-19 Vaccine</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>COVID-19 Booster</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Influenza</strong> <strong>THIS VACCINE IS STRONGLY RECOMMENDED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meningococcal Group B</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MenB-4C (Bexsero)</strong> OR <strong>MenB-FhbP (Trumenba)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV)</strong></td>
<td></td>
<td></td>
<td>3 doses at 0, 3 and 6 month intervals</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong> <strong>THIS VACCINE IS STRONGLY RECOMMENDED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis A &amp; B Combined</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**STRENGTHLY RECOMMENDED & ADDITIONAL IMMUNIZATIONS**

**Influenza**

**THIS VACCINE IS STRONGLY RECOMMENDED**

**Meningococcal Group B MenB-4C (Bexsero)**

**MenB-FhbP (Trumenba)** **THIS VACCINE IS STRONGLY RECOMMENDED**

**Human Papillomavirus (HPV)** **THIS VACCINE IS STRONGLY RECOMMENDED**

**Hepatitis A**

**Hepatitis A & B Combined**

Clinician’s Name (Please Print): ____________________________ Signature: ____________________________ Date: ________________

Address: (Including City and State): ________________________________ ___________________________________________________

Phone: (____) ___________ Fax: (____) ___________

Regis College Health Forms, Page 6 of 9 Revised: 7/14/2022 7:29 AM
REGIS COLLEGE TUBERCULOSIS RISK QUESTIONNAIRE

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)

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d'Ivoire
Democratic People's Republic of Korea
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People’s Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome and Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tokelau
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe


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 Health Forms, Page 7 of 9

Revised: 7/14/2022 7:29 AM
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 jejunoileal 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

Healthcare provider signature: (Required) ________________________________ Date: _____/_____/____

Healthcare Provider Name (Please print): ________________________________ Phone: (______)__________________

Regis College Health Forms, Page 8 of 9  Revised: 7/14/2022 7:29 AM
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.