# Your Health at Fisher College

## THE OFFICE OF STUDENT HEALTH SERVICES

At Fisher College, the health and wellness of our students is our top priority. After all, you can't learn and grow if you're not feeling your best.

To keep our students as healthy as possible, our Office of Student Health Services is staffed by a registered nurse and a part-time nurse practitioner who deliver a wide range of health services. We also provide counseling services and outpatient referrals to world-class hospitals and providers if they're needed.

The Office of Student Health Services is open Monday–Friday, 8 am to 4 pm. Counseling services are also available Monday through Friday by calling **617-236-8853** or **617-236-8894** to make an appointment. In addition, we have an on-site athletic trainer and offer many wellness services.

In order to welcome you to campus, we need to have all medical paperwork completed. Massachusetts has strict requirements that you must comply with to move into the residence halls and register for classes. Up-to-date immunizations will protect you from illness and help keep the Fisher community safe. **You will not be able to attend classes or live in the residence halls until we receive completed medical documents.**

If you haven't turned in the required documents by August 1st for Fall enrollment and January 2nd for Spring enrollment, it's your responsibility to complete the required forms in a timely manner. If you are unable to comply with the requirements before you arrive on campus, we will assist you through the process.

### YOU'LL NEED TO COMPLETE:

#### HEALTH RECORDS

» Permanent address and contact information
» Address and contact information while in school
» Emergency contacts
» Consent to treat in an emergency (students under the age of 18)

#### MEDICAL HISTORY

» Family history (include all that apply)
» Individual history (check all that apply)
» Hospitalizations
» Allergies (food, drug, etc.)
» Lifestyle questions

#### HEALTH INSURANCE *(required by law)*

» Automatically enrolled if no other comparable insurance plan is available
» Submit online waiver request if personal insurance plan meets state requirements
» Please note the important deadline date for the online waiver process.

### YOUR HEALTHCARE PROVIDER WILL NEED TO COMPLETE:

#### IMMUNIZATIONS FORM

You must be up-to-date with Massachusetts requirements for immunization.

» **Measles/Mumps/Rubella (MMR):** 2 doses given 30 days apart. Serological proof of immunity may be substituted.
» **Varicella (Chicken Pox):** 2 doses given 30 days apart. Serological proof of immunity or medical provider's documentation of the disease may be substituted.
» **Meningococcal vaccine:** (MenACWY) is required for all full-time newly enrolled students 21 years of age or younger (<22 years of age) received on or after the 16th birthday, regardless of housing status. Students may opt out of this requirement by reading and signing a waiver after discussion with a healthcare provider.
» **Tuberculosis screening and testing:** All students need to complete our TB Screening Questionnaire. May need testing based on answers.
» **Hepatitis B vaccine:** 3 doses are required. You are able to begin classes after receiving the first dose. You receive the second dose after 30 days and the third dose at least two months from the second dose and four months from the first. Serological proof of immunity may be substituted.
» **Tetanus Booster Shot:** TDap is required every 10 years.

#### RECOMMENDED IMMUNIZATIONS

» **Influenza**
» **Covid-19 vaccines**

#### PHYSICAL EXAMINATION

Please submit a record of physical examination performed and dated within one calendar year. Please make note of any areas of concern or chronic treatment. All student athletes are required to submit physical exams yearly.

**Completed paperwork may be mailed to:**
Office of Student Health Services
118 Beacon Street, Boston, MA 02116
**Fax to:** 617-236-5465
**Or email to:** healthservices@fisher.edu



Please return to Health Services at 118 Beacon Street, Boston, MA 02116



# HEALTH REGISTRATION FORM

FISHER COLLEGE
Fisher College Health Services
118 Beacon Street, Boston, MA 02116
**Phone:** 617-236-8860 **Fax:** 617-236-5465

Student completes this form. Please return directly to Fisher College Health Services.

**PLEASE NOTE:** ALL STUDENTS are required to return the HEALTH and IMMUNIZATION REPORT by August 1 for Fall enrollment and January 2 for Spring enrollment. Students who are admitted after this date must bring their forms to check-in day. Any student failing to provide this required documentation will be prohibited from registering and attending classes.

**INSTRUCTIONS:** This form must be completed in **ENGLISH.** Please complete all forms labeled ***STUDENT COMPLETES THIS FORM.*** Please have the student's healthcare provider complete and return all forms labeled ***HEALTHCARE PROVIDER COMPLETES THIS FORM.***

Name: _____ Date of Birth: _____
Last First MI Month Day Year

Legal Sex: ☐ Male ☐ Female Gender Identity: ☐ Male ☐ Female ☐ Other: _____

Permanent Address: _____
Street and Number City State Zip

E-mail Address: _____ Birthplace (Country): _____

Home Telephone: ( _____ ) ( _____ )_____ Cell Phone: ( _____ ) _____
Country Code if International Area Code Area Code

Local Address: _____
Street and Number City State Zip

Father/Guardian's Name: _____ Mother/Guardian's Name: _____

Father/Guardian's Home Phone: ( _____)_____ Mother/Guardian's Phone: (_____ ) _____

Father/Guardian's Business Phone: ( _____)_____ Mother/Guardian's Business Phone: (_____) _____

Semester/year entering Fisher College: _____ Status: ☐ Freshman ☐ Transfer Living: ☐ Resident ☐ Commuter

College(s) attended: _____ Dates attended: _____

### Alternate Emergency Contact

Name: _____
Last First Relationship

Home Telephone: (_____)_____ Cell Phone: (_____ ) _____

E-mail Address: _____

### CONSENT FOR EMERGENCY TREATMENT

**To be signed by parent/guardian if student is under 18 years of age:**

I give permission for medical treatment for my son/daughter.

_____

In the event of an accident or illness, this includes referral to a local hospital, hospitalization, anesthesia, and/or surgery should it be necessary and I am unable to be reached.

_____
Signature Date

### CONSENT FOR EMERGENCY TREATMENT

**To be signed by student over 18 years of age:**

I consent to care at Fisher College Health Services.

_____
Signature Date

**FOR HEALTH SERVICES USE ONLY**

Date Received:_____

Allergies:_____

_____

_____

_____

_____

☐ Complete ☐ Rubella ☐ CXR
☐ Exemption ☐ TDaP ☐ Physical Exam
Measles ☐ #1 ☐ #2 ☐ PPD ☐ Labs
Mumps ☐ #1 ☐ #2 ☐ MCV Varicella ☐ #1 ☐ #2 ☐ CP
Hepatitis B ☐ #1 ☐ #2 ☐ #3 Influenza ☐
COVID-19 ☐ #1 ☐ #2 ☐ #3

# MEDICAL HISTORY

**STUDENT** COMPLETES THIS FORM

Student Name:_____

Please return directly to Fisher College Health Services.

## FAMILY HISTORY

| Please list all family members | Age | Health Status | Age at death | Cause of death |
|---|---|---|---|---|
| Father | | | | |
| Mother | | | | |
| Brothers | | | | |
| | | | | |
| | | | | |
| Sisters | | | | |
| | | | | |
| | | | | |
| Spouse | | | | |
| | | | | |
| Children | | | | |
| | | | | |
| | | | | |

**Have any of your immediate relatives had any of the following:**

| Illness | ✓ for yes | Specify which relative |
|---|---|---|
| Alcoholism/Substance Abuse | | |
| Asthma or Allergies | | |
| Blood or Bleeding Disorder | | |
| Cancer | | |
| Diabetes | | |
| Heart Disease/ High Blood Pressure | | |
| Kidney Disease | | |
| Mental Illness (please specify): | | |
| Seizure Disorder | | |
| Tuberculosis | | |
| Other (please specify): | | |

## STUDENT'S HISTORY

**Do you have now or have you ever had:** *(check all that apply)*

1. ☐ Abnormal Pap
2. ☐ Anemia/Bleeding Disorder
3. ☐ Anorexia Nervosa/Bulimia
4. ☐ Appendectomy
5. ☐ Arthritis
6. ☐ Anxiety
7. ☐ Asthma
8. ☐ Bone or Joint Problem
9. ☐ Cancer/Malignancy
10. ☐ Chickenpox
11. ☐ Colitis/Ileitis
12. ☐ Diabetes
13. ☐ Depression
14. ☐ Frequent ear problems
15. ☐ Eye problem
16. ☐ Fainting
17. ☐ Severe head injury
18. ☐ Heart disease/problem
19. ☐ Heart murmur/click
20. ☐ Hepatitis/Jaundice
21. ☐ High blood pressure
22. ☐ HIV infection
23. ☐ Impaired mobility/paralysis
24. ☐ Individualized Education Plan
25. ☐ Irregular heartbeat
26. ☐ Irritable Bowel Syndrome
27. ☐ Kidney stone
28. ☐ Kidney disease/urinary infection
29. ☐ Learning disability
30. ☐ Malaria
31. ☐ Recurrent headache
32. ☐ Mononucleosis
33. ☐ Neuro-muscular disease
34. ☐ Phlebitis/deep vein clot
35. ☐ Pneumothorax
36. ☐ Positive TB test
37. ☐ Rheumatic fever
38. ☐ Seizure disorder
39. ☐ Sickle cell disease/trait
40. ☐ Testicular problem
41. ☐ Thyroid disease
42. ☐ Tuberculosis
43. ☐ Ulcer
44. ☐ Other serious illness or injury, mental illness (please explain below)

_____

_____

_____

Do you smoke? ☐ No ☐ Yes
How many cigarettes a day? _____ For how many years?_____

Do you drink alcohol? ☐ No ☐ Yes How often? _____
If you drink, how may drinks do you have on the average in one evening?
_____

Do you exercise? ☐ No ☐ Yes What type? _____
How often?_____

When you travel in a car, what percentage of the time do you wear a seatbelt? _____ %

Do you wear a helmet when biking/roller blading? ☐ No ☐ Yes

Do you examine your breasts/testicles regularly? ☐ No ☐ Yes

Do you follow any special diet? ☐ No ☐ Yes
What kind? _____

Are you concerned about your eating patterns? ☐ No ☐ Yes

Or your weight? ☐ No ☐ Yes

Do you consider yourself:
☐ underweight ☐ overweight ☐ normal weight

Do you often have a feeling of being overwhelmed or depressed?
☐ No ☐ Yes

Have you ever received treatment or counseling for an emotional problem?
☐ No ☐ Yes

Are you concerned about your own drinking or drug use? ☐ No ☐ Yes

## MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS:

*(If any, provide details including dates, diagnoses, surgeries, etc.)*

_____

_____

CURRENT MEDICATIONS:

_____

_____

ALLERGIES (Please specify):

_____

_____

## GYNECOLOGICAL HISTORY:

*(female students only – check all that apply)*

Age at onset of menstrual cycle:_____ Length of cycle:_____

Date of last PAP smear: _____ Result: _____

Have you ever had: ☐ Colposcopy (Date) _____

☐ Irregular periods/no periods ☐ Painful cramps ☐ PID ☐ STI ☐ PCOS

☐ Bleeding between periods ☐ Breast lumps/Fibrocystic Disease

Explain all positive answers (please include dates):

_____

Please return to Health Services at 118 Beacon Street, Boston, MA 02116



# IMMUNIZATION RECORD

**HEALTHCARE PROVIDER** COMPLETES THIS FORM

**FISHER COLLEGE STUDENT IMMUNIZATION FORM**
Health Services | 118 Beacon Street | Boston, Massachusetts 02116
Phone: 617-236-8860 | Fax: 617-236-5465

**Please return directly to Fisher College Health Services.**

This form must be completed and returned to Health Services before you arrive on campus. All responses must be in English.

You may:
1) **Complete the student information section. Attach immunization documentation from your healthcare provider's office, school, or military records, or**
2) **Complete the student information section. Have your healthcare provider complete the remaining sections and sign where indicated, or**
3) **Email the completed forms to healthservices@fisher.edu.**

## STUDENT INFORMATION

First Name Last Name

/ /
Date of Birth Home Phone # Cell Phone #

Home Address

City State Zip

## REQUIRED IMMUNIZATIONS

**Tetanus / Diphtheria/ Acellular Pertussis** *(one booster)*

TDaP ___ / ___ / ___ *(within 10 years)*
MM DD YY
TD ___ / ___ / ___
MM DD YY

**Meningitis ACWY**

Vaccine ___ / ___ / ___ Type _____ *(refer to enclosed guidelines)*
MM DD YY

*One dose of MenACWY for newly enrolled full-time students 21 years of age and younger (<22 years of age) received on or after the 16th birthday, regardless of housing status or signed waiver (on page 12).

**Varicella** *(Two doses required)*

☐ Varicella #1:___ / ___ / ___ #2: ___ / ___ / ___
MM DD YY MM DD YY
or
☐ Positive Blood Titer: ___ / ___ / ___ *(attach copy of lab results)*
MM DD YY
☐ Had disease (Chickenpox) ___ / ___ / ___
MM DD YY

**Measles - Mumps - Rubella (MMR)** *(Two doses required)*

MMR#1: ___ / ___ / ___ *(First dose must be after age 12 months)* MMR#2:___ / ___ / ___ *(Must be at least one month after dose #1)*
MM DD YY MM DD YY
or
Measles vaccine #1: ___ / ___ / ___ #2: ___ / ___ / ___ Mumps vaccine #1: ___ / ___ / ___ #2: ___ / ___ / ___ Rubella vaccine: ___ / ___ / ___
MM DD YY MM DD YY MM DD YY MM DD YY MM DD YY
or
☐ Positive Blood Titers: *(attach copy of lab results)* Measles (Rubeola): ___ / ___ / ___ Mumps: ___ / ___ / ___ Rubella: ___ / ___ / ___
MM DD YY MM DD YY MM DD YY

**Hepatitis B** *(Three doses required)*

#1:___ / ___ / ___ #2: ___ / ___ / ___ *(Must be at least one month after dose #1)* #3: ___ / ___ / ___ *(Must be at least two months after dose #2 and four months after #1)*
MM DD YY MM DD YY MM DD YY
or
☐ Positive Blood Titer: ___ / ___ / ___ *(attach copy of lab results)*
MM DD YY

## RECOMMENDED IMMUNIZATIONS

**Covid Vaccine**

#1 ___ / ___ / ___ _____ #3 ___ / ___ / ___ _____
MM DD YY VERSION MM DD YY VERSION
#2 ___ / ___ / ___ _____
MM DD YY VERSION

**Influenza**

Vaccine ___ / ___ / ___
MM DD YY

**Health Care Provider** *(please print)*

Address Phone/Fax Provider's Signature

Please return to Health Services at 118 Beacon Street, Boston, MA 02116

# TB SCREENING QUESTIONNAIRE

Student Name: _____

**PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE** *(to be completed by incoming student)*

## Please answer the following questions:

1. Have you ever had a positive tuberculosis (TB) test? If yes, please refer to Section B in part 2 below. ☐ No ☐ Yes
2. Have you ever had close contact with persons known or suspected to have active tuberculosis (TB)? ☐ No ☐ Yes
3. Were you born in one of the countries or territories listed below? ☐ No ☐ Yes
4. Have you ever traveled or lived for more than a month in any of the countries or territories listed below? ☐ No ☐ Yes

If yes, please circle the country or territory below: *Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2018. Countries with incidence rates of ≥ 20 cases per 100,000 population. For future updates, refer to http://www.who.int/tb/country/en/.*

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia (Plurinational State of)
Bosnia & 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
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Libya
Lithuania
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Nive
Northern Mariana Island
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome & Principe
Senegal
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
Sri Lanka
Sudan
Suriname
Tajikistan
Thailand
Timor-Leste
Togo
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
United Republic of Tanzania
Uruguay
Uzbekistan
Vanuatu
Venezuela (Bolivarian Republic of)
Viet Nam
Yemen
Zambia
Zimbabwe

## MEDICAL EVALUATION FOR LATENT TUBERCULOSIS INFECTION

To be completed and signed by a licensed healthcare provider ONLY if student answers "yes" to 2, 3, or 4 above.

**Please note:**
If patient has had a POSITIVE TUBERCULOSIS SKIN TEST in the past, the test should not be repeated. Go to Section B below.

### A. TUBERCULIN TESTING (Mantoux/Intermediate PPD or Interferon Gamma Release Assay [IGRA])

1. Mantoux – Please note: Mantoux test must be read by a healthcare provider 48–72 hours after administration. If no Induration, mark "0". Results of multiple puncture tests, such as Tine or Mono – Vac are NOT accepted.

**Date administered:** ___ / ___ / ___ (MM DD YY) **Date test read:** ___ / ___ / ___ (MM DD YY) **Result:** _____ mm of induration

**Interpretation of Tuberculin Test:** (Please use table below and circle response.) Negative/Positive

| Risk Factor | Risk Factor |
|---|---|
| Close contact with case of TB | 5mm or more |
| Born in a country with a high rate of TB | 10mm or more |
| Traveled/lived for 1+ months in a country with high TB rates | 10mm or more |
| No risk factors (test not recommended) | 15mm or more |

or

2. Interferon Gamma Release Assay (IGRA)

**Method used:** *(Please check)* ☐ QFT – G ☐ Tspot **Date obtained:** ___ / ___ / ___ (MM DD YY)

**Result:** *(Please check appropriate response)* ☐ Negative ☐ Positive ☐ Intermediate ☐ Borderline

### B. POSITIVE SKIN TEST OR POSITIVE IGRA REQUIRES A CHEST X-RAY (Mantoux/Intermediate PPD or IGRA tests)

**1. Date of POSITIVE test:** ___ / ___ / ___ (MM DD YY) **Testing method:** *(please check)* ☐ Mantoux ☐ IGRA

**2. Chest X-Ray:** *(please check)* ☐ Normal ☐ Abnormal **Please attach a copy of the report** *(no discs or films)*

Describe: _____

**3. Clinical Evaluation:** *(please check)* ☐ Normal ☐ Abnormal

Describe: _____

**4. Treatment:** *(please check)* ☐ Yes ☐ No

Meds, Dose, Frequency, Dates: _____

## HEALTHCARE PROVIDER SIGNATURE

Unless documentation of immunization is attached, your healthcare provider's (M.D./N.P./P.A.) signature or stamp is required below.

**Healthcare provider signature or stamp:** _____

Date: ___ / ___ / ___ (MM DD YY) Address: _____ Phone: _____

Please return to Health Services at 118 Beacon Street, Boston, MA 02116





# INFORMATION ABOUT MENINGOCOCCAL DISEASE

Student Name: _____

## INFORMATION ABOUT MENINGOCOCCAL DISEASE & VACCINATION FOR STUDENTS AT SCHOOLS & COLLEGES

**FULL-TIME STUDENTS: Waiver is on page 12. Read and retain a copy of pages 11–12.**

**Colleges:** Massachusetts requires all newly enrolled full-time students 21 years of age and under attending a postsecondary institution (e.g., colleges) to: receive a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday to protect against serotypes A, C, W and Y **or** fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver on page 10 of this form. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

### What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitides*. 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 meningitis may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, and rash can all be signs of meningitis. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. In the US, about 1,000–2,000 people get meningococcal disease each year and 10–15% die despite receiving antibiotic treatment. Of those who live, another 11–19% loses 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 and 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 and people who may have been exposed to meningococcal disease during and outbreak. People who live in certain settings such as college freshmen living in residence halls and military recruits are also at greater risk of disease.

### Are some students in college and secondary schools at risk for meningococcal disease?

College freshmen living in residence halls and dormitories are at increased risk for meningococcal disease caused by some of the serotypes contained in the quadrivalent vaccine,as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (*alcohol consumption, exposure to cigarette smoke, sharing food and beverages, and activities involving exchange of saliva*), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, quadrivalent meningococcal vaccine is a safe and effective way to reduce their risk of contracting this disease. In general, the risk of invasive meningococcal B disease is not increased among college students relative to others of the same age not attending college. However, outbreaks of meningococcal B disease do occur, though rarely, at colleges and universities. Vaccination of students with meningococcal B vaccine may be recommended during outbreaks.

### Is there a vaccine against meningococcal disease?

Yes, there are 2 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menveo) 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. 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 (16-32 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?

A vaccine, like any medication, is capable of causing serious problems such as severe allergic reactions, but these are rare. 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 1–2 days. A small percentage of people who received the vaccine develop a fever. The vaccine can be given to pregnant women. Anyone who has ever had Guillain-Barré Syndrome should talk with their provider before getting meningococcal conjugate vaccine.

Please return to Health Services at 118 Beacon Street, Boston, MA 02116

STUDENT COMPLETES THIS FORM

# INFORMATION ABOUT MENINGOCOCCAL DISEASE

## Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or 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 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, 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.

## 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)*

*Provided by: Massachusetts Department of Public Health, Division of Epidemiology and Immunization: 617-983-6800, MDPH Meningococcal Information and Waiver Form 01/18*

Student's Name: _____

**Read meningococcal disease information on pages 11 and 12 before signing.**

## 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 vaccine. I understand that Massachusetts' law requires newly enrolled full-time students 21 years of age and younger at secondary schools, colleges, and universities to receive one dose of MenACWY vaccine administered on or after their 16th birthday, unless the student provides a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

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

Student name: _____ Date of birth: ___ / ___ / ___ Student ID #: _____
MM DD YY

Signature: _____ Today's date: ___ / ___ / ___
*(Student, or parent/legal guardian if student is under 18 years of age)* MM DD YY

*Provided by: Massachusetts Department of Public Health, Division of Epidemiology and Immunization: 617-983-6800, MDPH Meningococcal Information and Waiver Form 01/18*

Please return to Health Services at 118 Beacon Street, Boston, MA 02116



HEALTHCARE PROVIDER COMPLETES THIS FORM

# PHYSICAL EXAMINATION

Please return directly to Fisher College Health Services.

*Must be completed within one year of August 1 for Fall enrollment, January 2 for Spring enrollment, and within six months of enrollment for athletics.*

Student's Name: _____ Date of Birth: _____

Height _____ Weight _____ BP _____ Pulse _____

Hearing: Right _____ Left _____

Vision: Without correction: Right 20/ _____ Left 20/_____ With correction: Right 20/_____ Left 20/_____

Color vision normal: ☐ Yes ☐ No TB low risk: ☐ Yes ☐ No

**The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.**

| System | ✓ If Normal | Describe Abnormality |
|---|---|---|
| Skin | | |
| HEENT | | |
| Lungs/Chest | | |
| Breasts | | |
| Heart/Vascular System | | |
| Abdomen (rectal if indicated) | | |
| Genito-urinary/Reproductive | | |
| Pelvic | | |
| Lymphatic | | |
| Musculo-skeletal | | |
| Neurological | | |
| Endocrine | | |
| Psychological | | |
| Teeth/Mouth | | |
| Lab work: Hgb/Hct_____ Urine: Glucose_____ Protein_____ | | |

**List all current medications:**

**List all known allergies:**
***(medications, food, substances)***

**CURRENT MAJOR AND CHRONIC PROBLEMS:**

**ACUTE OR MINOR PROBLEMS:**

*If the student is under care for a chronic condition or serious illness, please provide additional clinical reports to assist us in providing continuity of care.*

Please comment on any physical or emotional problems that Health Services should be aware of regarding this patient, including past history, medications, and current treatments:

☐ Please check if the student intends to participate in intercollegiate athletics. Please indicate team: _____

**INTERCOLLEGIATE ATHLETES ONLY:** PE required within 6 months of enrollment. Attach a copy of sickle cell screening lab report, if necessary. Attach healthcare provider's certification of any NAIA banned substance with diagnosis, Rx, date prescription began, date of last evaluation, history of treatment (previous or ongoing), ADHD rating scale (if applicable), note that alternative non-banned substances have been considered.

Recommendations for physical activity: ☐ unlimited ☐ limited (specify)_____

☐ Medically cleared for sports participation ☐ Cleared after completing evaluation/rehabilitation for: _____

☐ Do not clear. Reason: _____

**MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER** (please print) **DATE OF EXAM:** _____

Health Care Provider _____ MD, NP, PA, DO

Address _____

Phone (_____) _____ Fax (_____)_____

Provider's Signature: _____

Please return to Health Services at 118 Beacon Street, Boston, MA 02116