ENTRANCE HEALTH REPORT

Student Information

Date of Birth | Expected Graduation Year

Last Name | First Name | Middle Initial

Home Address

City | State | Zip Code

Home Phone Number | Cell Phone Number

Parent Information

Father's Last Name | First Name

Home Address

City | State | Zip Code

Home Phone Number | Work Phone Number

Mother's Last Name | First Name

Home Address

City | State | Zip Code

Home Phone Number | Work Phone Number

Health Insurance Information

If possible, please attach a copy of the front and back of the Health Insurance card

Insurance Company Name | Policy #

Group # | Policy Holder Name | Relationship

Contact # for out of plan service | Is this an HMO? Yes/No

If Insurance plan changes, please notify Health Services and update insurance information at healthservices@emmanuel.edu

Permission for Medical & Emergency Treatment

This information must be completed and signed by a parent or legal guardian for students under 18 years of age.

Medical and Psychological Treatment, including medication: This is to certify that permission is granted to Emmanuel College Student Health Services and Counseling Center to provide psychological treatment and medical treatment, including medication, for illness, injury or required immunizations for the above named student

Signature of parent or legal guardian

Emergency Treatment: Permission is granted for emergency treatment (including, psychological, psychiatric, surgery and anesthesia) for above named student, when parent or guardian is unable to be contacted.

Signature of parent or legal guardian

When finished, please return to:
Student Health Services
Emmanuel College
400 The Fenway
Boston, MA 02115

E-mail: healthservices@emmanuel.edu
Fax: 617 975-9329

DEADLINE: JANUARY 11, 2019

NOTE:
The Entrance Health Report is a separate requirement from documentation of student health insurance coverage.

To enroll or waive the College's health insurance coverage, please visit **universityhealthplans.com**

STUDENT NAME: _____

Please list all current medications including dosages:

Please list and describe any medication allergies you have:

Please list all past and current medical and/or mental health diagnoses:

Please list all hospitalizations (including medical, surgical or psychiatric admissions):

Health Care Provider Information

Health Care Provider's Signature _____ Date _____

Health Care Provider's Name (please print) _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ Fax Number _____

○ NP

○ MD

Health Services shares information on the Entrance Health Report with the Counseling Center and immunization records with the College Administration on a need-to-know basis.

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Immunization Requirements

Failure to provide a record of your immunization will result in registration restrictions and withholding of grades.

Massachusetts State Law requires that all students attending college in the Commonwealth be immunized against the Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria & Acellular Pertussis (Tdap), and Hepatitis B. ***Meningitis and Human Papillomavirus (HPV) are strongly recommended but not required.***

Proof of the following must be on file at Student Health Services: *If you do not have access to these records, you must be re-immunized.*

Measles, Mumps, Rubella, (MMR)	First dose _____ Date Second Dose _____ Date	OR ○ Laboratory evidence of immunity to measles, mumps and rubella attached
Hepatitis B	First Dose _____ Date Second Dose _____ Date Third Dose _____ Date	OR ○ Laboratory evidence of immunity attached
Meningitis *MenACWY within the past five years and after age 16.*	_____ Date	OR ○ Waiver signed and attached (waiver available on website)
Tdap *Must be within past 10 Years*	Tetanus, Diphtheria & Acellular Pertussis (Tdap)	_____ Date
Tuberculosis Risk Assessment	Low Risk OR High Risk	Please complete Tuberculosis Risk Questionnaire
Varicella	First dose _____ Date Second Dose _____ Date	OR ○ Laboratory evidence of immunity to Varicella ○ History of Varicella Disease _____ Date
Human Papillomavirus (HPV)	First Dose _____ Date Second Dose _____ Date Third Dose _____ Date	

STUDENT NAME:_____

Tuberculosis Risk Questionnaire for College and University Student

To the best of your knowledge, have you ever had close contact with anyone who was sick with tuberculosis (TB)?	○ Yes	○ No
Were you born in one of the countries listed below?	○ 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 in a medical facility or other patient care setting?	○ Yes	○ No
Have you ever traveled or lived abroad for more than 6 months in one or more of the countries listed below (*Please circle below)*	○ Yes	○ No

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

Angola	Indonesia	Papua New Guinea
Bangladesh	Kenya	Philippines
Brazil	Korea, DPR	Russian Federation
Cambodia	Lesotho	Sierra Leone
Central African Rep.	Liberia	South Africa
China	Mozambique	Tanzania, UR
Congo	Myanmar	Thailand
Congo, DR	Namibia	Vietnam
Ethiopia	Nigeria	Zambia
India	Pakistan	Zimbabwe

**World Health Organization, 2015 American College Health Association guidelines, April 2014*

If the answer to any of the above questions is YES, the Massachusetts Department of Public Health strongly recommends that you have a turberculin skin test to check for latent turberculosis infection. If the answer to all of the above questions is NO, a turberculin skin test should not be done.

Please note: If you have had a positive tuberculin skin test in the past, you do not need another test.

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PLEASE FEEL FREE TO CONTACT STUDENT HEALTH SERVICES BY PHONE AT 617-264-7678 WITH ANY QUESTIONS OR CONCERNS.