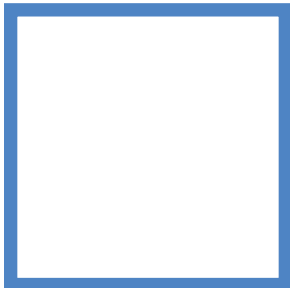


# Entrance Health Report

Please review your Health Forms using the checklist below to be sure you and your Health Care Provider complete all required information. Students will not be allowed to move into the residence halls or register for classes until all of the required health forms are on file.

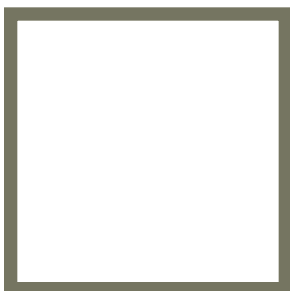
**Deadline: Friday, July 10, 2009**



## TO BE COMPLETED BY THE INCOMING STUDENT

These pages are marked in blue throughout this report.

- Demographic Information . . . . . 3
- Family History . . . . . 3
- Student's Medical History . . . . . 4
- Insurance Information . . . . . 5  
*Please be aware that you will be required to submit Insurance Information to Student Financial Services and to Athletics, if you are participating in athletics.*
- Permission for Medical & Emergency Treatment . . . . . 5  
*This section must be completed by the parent or legal guardian if the incoming student is under 18.*
- Meningococcal Vaccination Waiver . . . . . 7-8  
*This form must be filled out and signed if you have declined vaccination.*
- Tuberculosis Risk Questionnaire . . . . . 9
- Make a copy of completed Health Forms to save for your records



## TO BE COMPLETED AND SIGNED BY THE HEALTH CARE PROVIDER

These pages are marked in grey throughout this report.

- Medical Evaluation for Latent Tuberculosis Infection . . . . . 10
- Physical Exam . . . . . 11
- Immunization Requirements . . . . . 12

Please return all completed forms in the envelope provided to:

Student Health Services  
Emmanuel College  
400 The Fenway  
Boston, MA 02115  
617-264-7678

For inquiries May through August, call 617-735-9920

# Student Information



## Demographic Information

It is important that you provide a complete address.

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

**Deadline:  
 Friday, July 10, 2009**

..... Entrance Date

..... Last Name First Name Middle Initial

Male  Female

..... Date of Birth Expected Graduation Year

..... Home Address (Apt. No., Street, Post Office Box, etc.) City State Zip Code

..... Home Phone Number Cell Phone Number

..... Father's Name Occupation

..... Home Address (Apt. No., Street, Post Office Box, etc.) City State Zip Code

..... Home Phone Number Work Phone Number

..... Mother's Name Occupation

..... Home Address (Apt. No., Street, Post Office Box, etc.) City State Zip Code

..... Home Phone Number Work Phone Number

..... Emergency Contact Relation to Student

..... Home Phone Number Work Phone Number

..... Home Address (if different than above) City State Zip Code

## Family History

..... **Father**

Age General Health Past/Present Illness If deceased, cause of death

..... **Mother**

Age General Health Past/Present Illness If deceased, cause of death

..... **Siblings**

M/F Age General Health Past/Present Illness If deceased, cause of death

M/F Age General Health Past/Present Illness If deceased, cause of death

M/F Age General Health Past/Present Illness If deceased, cause of death

Please indicate below if any of your family has had the following:

- Alcoholism
- Asthma
- Cancer
- Drug Abuse
- Epilepsy
- Heart Disease (before age 55)
- High Cholesterol
- Hypertension
- Psychiatric Disorder
- Stroke
- Tuberculosis
- Other: \_\_\_\_\_



Student's Medical History

Please list all medications and dosage you are currently taking:

.....  
.....

Please list and describe any medication allergies you have:

.....  
.....

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

Please list current medical problems:

.....  
.....

**Deadline:**  
**Friday, July 10, 2009**

Please indicate below if you have had the following:

- Allergies
- Alcohol/drug problems
- Anorexia/Bulimia
- Asthma
- Blood Disorders
- Blood Transfusions
- Cancer
- Chicken Pox
- Diabetes
- Depression
- Ear Infections
- Eye Problems/Trauma
- Fainting/spells
- German Measles
- Head injury
- Headaches
- Heart Disease
- Hepatitis
- High Cholesterol
- Hypertension
- Irritable Bowel Syndrome
- Kidney Disease
- Liver Disease
- Malaria
- Menstrual Cycle:  
# periods in last year: \_\_\_\_\_
- Mononucleosis
- Numbness/tingling
- Pneumonia
- Panic Attacks
- Psychiatric Disorders
- Sickle Cell Disease
- Skin Disorder: acne, eczema, tinea
- Seizures
- Sexually transmitted diseases
- Thyroid Disorder
- Tuberculosis
- Ulcers
- Other (please explain): \_\_\_\_\_  
\_\_\_\_\_

Regarding sports related illness or injury, please complete the following:

1. Have you ever had trouble with sports or physical activity (passed out, chest pain, shortness of breath, etc.)?

Yes    No   .....  
If yes, please describe

2. Have any restrictions ever been placed on you as to the amount and nature of your physical activity?

Yes    No   .....  
If yes, please describe

3. Do you use any special protective/assistive equipment (knee brace, hearing aid, orthotics, retainers, etc.)?

Yes    No   .....  
If yes, please describe

4. Have you ever had any of the following sports injuries or hospitalizations?

	Yes	No	Date
Neck injury (stingers, burners, disc injury)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shoulder/Elbow (separation, dislocation, fracture)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Wrist/Hand (fracture)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hip/Thigh (sacroiliac, femur)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Upper/Lower Back (disc herniation, spondilolysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Knee (patella pain, ligament sprain, meniscus)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lower Leg (fracture, stress fracture)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ankle (sprain, dislocation, fracture)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Foot (sprain, fracture)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery	<input type="checkbox"/>	<input type="checkbox"/>	_____

.....  
If yes to surgery, please describe

I hereby certify that the above information is complete and accurate.

.....  
Student Signature

.....  
Date

Insurance Information  
This information must be provided.



.....  
Student Last Name First Name Middle Initial

- I plan to be covered by school insurance.
- I will be covered by:

.....  
Name of Insurance Company

.....  
Policy Number

.....  
Name of Policy Holder

.....  
Social Security Number of Policy Holder

Does your insurance company require prior approval for specialty referrals?

- Yes
- No

.....  
If yes, contact names and telephone number

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

**Deadline:**  
**Friday, July 10, 2009**

Permission for Medical & Emergency Treatment

This information must be completed and signed by parent or legal guardian if student is **under 18**.

.....  
Student Last Name First Name Middle Initial

Medical treatment:

This is to certify that permission is granted to Emmanuel College Student Health Services to provide medical treatment for illness, injury or required immunizations for the above-named student.

.....  
Signature of parent or legal guardian

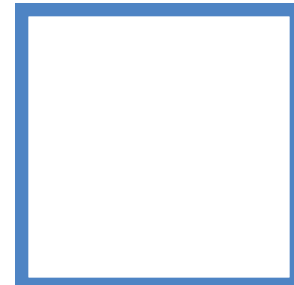
Emergency treatment:

Permission is granted for emergency treatment (including surgery & anesthesia) for above named student, when parent or guardian is unable to be contacted.

.....  
Signature of parent or legal guardian

In all cases, reasonable effort will be made to contact parent or guardian prior to treatment.

# Information about Meningococcal Disease & Vaccination and Waiver for Students at Residential Schools & Colleges



Legislation has been enacted in Massachusetts requiring all new students at residential schools (e.g., boarding schools) with grades 9-12 and postsecondary institutions (e.g., colleges) that provide or license housing to:

1. receive meningococcal vaccine prior to the beginning of classes; or
2. fall within one of the exemptions in the law, which are discussed below.

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 at the end of this document. 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 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. In the United States, about 2,600 people each year get meningococcal disease and 10-15% die despite receiving antibiotic treatment. Of those who survive, about 10% may lose limbs, become deaf, have seizures or strokes, or have other problems with their nervous system.

## 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, sneezing, coughing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected.

## Who has the greatest risk of getting meningococcal disease?

People who travel to certain parts of the world where the disease is very common are at risk, as are military recruits who live in close quarters. Children and adults with damaged or removed spleens or an inherited disorder called “terminal complement component deficiency” are at higher risk.

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

College freshmen living in residence halls or dormitories

are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the 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, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

## Is there a vaccine against meningococcal disease?

Yes, there are currently two vaccines available that protect against four of the most common of the 13 serogroups (subgroups) of *N. meningitidis* that cause serious disease. Meningococcal polysaccharide vaccine is approved for use for those two years of age and older. In January 2005, a new type of meningococcal vaccine was licensed, called meningococcal conjugate vaccine, and is currently only approved for use for those 11-55 years of age. Both types of meningococcal vaccines are acceptable for college students and residential school students 11 years of age and older. For those younger than 11 years of age, meningococcal polysaccharide vaccine is the only licensed vaccine.

Both of the vaccines provide protection against four serogroups of the bacteria, called groups A, C, Y and W-135. These four serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. Most of the remaining one-third of the cases are caused by serogroup B, which is not contained in the vaccine. Protection from immunization with the meningococcal polysaccharide vaccine is not lifelong; it lasts about 3-5 years in healthy adults (some people may be protected longer). The meningococcal conjugate vaccine is expected to help decrease disease transmission and provide more long-term protection.

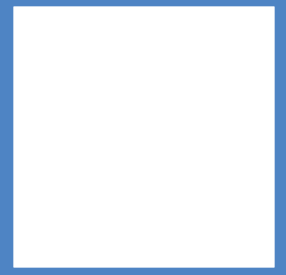
## Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. The risks associated with receiving the vaccine are much less significant than the risks that would arise in a case of meningococcal disease. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal

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Emmanuel College  
400 The Fenway  
Boston, MA 02115

**Deadline:  
Friday, July 10, 2009**



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.

Is it mandatory for students to receive meningococcal vaccine prior to entering secondary schools or colleges that provide or license housing?

Massachusetts law (MGL Ch. 76, s.15D) requires new students at residential schools (e.g., boarding schools) with grades 9-12 and new full- and part-time, undergraduate and graduate students in degree-granting programs at postsecondary institutions (e.g., colleges) that provide or license housing to receive meningococcal vaccine. At affected institutions, the new requirements apply to all new students, regardless of grade (including grades pre-K through 8), year of study, and whether or not they reside in school- or campus-related housing. Since August 2005, all new students at these institutions have had to provide documentation of having received meningococcal vaccine (within the last five years) at least two weeks prior to the beginning of classes, unless they qualified for one of the exemptions allowed by the law.

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,

**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 meningococcal vaccine. I understand that Massachusetts' law requires students enrolled at secondary schools, colleges and universities that provide or license housing 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.

Please check the appropriate box below:

- After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.
- Due to the shortage of meningococcal vaccine, I was unable to be vaccinated.

.....  
Last Name

.....  
First Name

.....  
Middle Initial

.....  
Date of Birth

.....  
Student ID or SSN

.....  
Signature of student or parent/legal guardian, if student is under 18

.....  
Date

- 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.

Consideration is being given to amending the law regarding the students to be covered by the requirement. When and if the law is amended, regulations regarding meningococcal vaccination may change.

**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 this vaccine. 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](http://www.mass.gov/dph)
- 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

June 2006

# Tuberculosis Risk Questionnaire for College and University Students

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

**Deadline:  
 Friday, July 10, 2009**

.....

Last Name	First Name	Middle Initial
-----------	------------	----------------

1. To the best of your knowledge have you ever had close contact with anyone who was sick with tuberculosis (TB)?

Yes    No

2. Were you born in one of the countries listed below?

Yes    No

3. Have you traveled or lived for more than one month in one or more of the countries listed below?

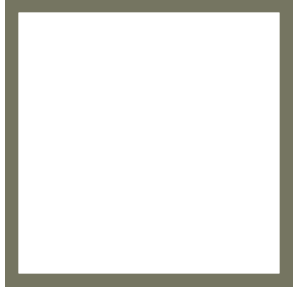
Yes    No

Countries with High Rates of Tuberculosis (TB)\*

Afghanistan	Djibouti	Lesotho	Peru
Angola	Dominican Rep.	Liberia	Philippines
Armenia	Ecuador	Lithuania	Portugal
Azerbaijan	El Salvador	Macedonia, TFYR	Romania
Bahamas	Equatorial Guinea	Madagascar	Russian Federation
Bahrain	Eritrea	Malawi	Rwanda
Bangladesh	Estonia	Malaysia	Sao Tome & Principe
Belarus	Ethiopia	Maldives	Senegal
Benin	Gabon	Mali	Sierra Leone
Bhutan	Gambia	Marshall Islands	Solomon Islands
Bolivia	Georgia	Mauritania	Somalia
Bosnia & Herzegovina	Ghana	Mauritius	South Africa
Botswana	Guam	Micronesia	Sri Lanka
Brazil	Guatemala	Moldova, Rep.	Sudan
Brunei Darussalam	Guinea	Mongolia	Suriname
Burkina Faso	Guinea-Bissau	Morocco	Swaziland
Burundi	Guyana	Mozambique	Syrian Arab Rep.
Cambodia	Haiti	Myanmar	Tajikistan
Cameroon	Honduras	Namibia	Tanzania, UR
Cape Verde	India	Nepal	Thailand
Central African Rep.	Indonesia	New Caledonia	Togo
Chad	Iran	Nicaragua	Tokelau
China	Iraq	Niger	Turkmenistan
China, Hong Kong SAR	Kazakhstan	Nigeria	Uganda
China, Macao SAR	Kenya	Niue	Ukraine
Colombia	Kiribati	Northern Mariana Islands	Uzbekistan
Comoros	Korea, DPR	Pakistan	Vanuatu
Congo	Korea, Rep.	Palau	Vietnam
Congo, DR	Kyrgyzstan	Panama	Yemen
Cote d'Ivoire	Lao PDR	Papua New Guinea	Zambia
Croatia	Latvia	Paraguay	Zimbabwe

\* World Health Organization. Global tuberculosis control. WHO report 2002.

If the answer to **any** of the above questions is **YES**, the Massachusetts Department of Public Health **strongly recommends** that you have a tuberculin skin test to check for latent tuberculosis infection. If the answer to **all** of the above questions is **NO**, you do not need a skin test so have your physician indicate low risk below and sign this form. If you have had a positive tuberculin skin test in the past, you do not need another one.



# Medical Evaluation of College and University Students for Latent Tuberculosis Infection

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

**Deadline:**  
**Friday, July 10, 2009**

.....  
Student's Last Name First Name Middle Initial

### Risk Assessment Score

Please check one of the following:

- Low (if low, no test needed) — *Health Care Provider, please sign below.*
- High (skin test performed)
- Very High (skin test performed)

### Tuberculin Skin Test

..... mm of induration  
Date Performed Result (48-72 hours)  
(If no induration, mark "0")

Note: Use 5 TU Mantoux test (Intermediate PPD) only; result of multiple puncture tests, such as Tine or Mono-vacc, not accepted.

### Interpretation of Tuberculin Skin Test

Risk Factor Assessment	Positive Result Parameters
Very High—Close contact with a case of tuberculosis	5 mm or more
High—Born in a country that has a high rate of tuberculosis High—Traveled or lived for a month or more in a country that has a high rate of tuberculosis	10 mm or more
Low—None (test not recommended)	15 mm or more

### Risk-based Interpretation

- Negative
- Positive

If the Tuberculin Skin Test is positive:

### Chest X-ray

.....  
Date Performed  Normal  Abnormal .....  
If abnormal, please describe

### Clinical Evaluation

.....  
Date Performed  Normal  Abnormal .....  
If abnormal, please describe

### Treatment

- No
- Yes .....  
If yes, please describe (drug, dose, frequency and dates)

.....  
Health Care Provider's Signature Date

# Physical Exam

Date of Physical Exam\*: \_\_\_\_\_

\* Please note: physical exam must have been completed within the last 12 months.



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

.....  
 Student's Last Name First Name Middle Initial

.....  
 General Appearance

Vital Signs:

.....  
 Blood Pressure Pulse Weight Height

**Deadline:**  
**Friday, July 10, 2009**

Please check each item:

	Normal	Abnormal	If Abnormal, please describe:
Eyes	<input type="radio"/>	<input type="radio"/>	_____
Ears	<input type="radio"/>	<input type="radio"/>	_____
Nose/Sinus	<input type="radio"/>	<input type="radio"/>	_____
Throat/Tonsils	<input type="radio"/>	<input type="radio"/>	_____
Teeth/Gums	<input type="radio"/>	<input type="radio"/>	_____
Chest	<input type="radio"/>	<input type="radio"/>	_____
Lungs	<input type="radio"/>	<input type="radio"/>	_____
Heart	<input type="radio"/>	<input type="radio"/>	_____
Heart murmur with valsava	<input type="radio"/>	<input type="radio"/>	_____
Thyroid	<input type="radio"/>	<input type="radio"/>	_____
Breasts	<input type="radio"/>	<input type="radio"/>	_____
Abdomen	<input type="radio"/>	<input type="radio"/>	_____
Liver	<input type="radio"/>	<input type="radio"/>	_____
Lymph	<input type="radio"/>	<input type="radio"/>	_____
Spleen	<input type="radio"/>	<input type="radio"/>	_____
Rectum	<input type="radio"/>	<input type="radio"/>	_____
Pelvis/Genitourinary	<input type="radio"/>	<input type="radio"/>	_____
Neurologic Exam	<input type="radio"/>	<input type="radio"/>	_____
Rheumatologic	<input type="radio"/>	<input type="radio"/>	_____
Orthopedic Exam	<input type="radio"/>	<input type="radio"/>	_____
Skin	<input type="radio"/>	<input type="radio"/>	_____

\*Please complete attached immunization information and TB Risk assessment.

Recommendations:

.....  
 .....

Applicant may participate in sports:

- may participate without restrictions
- with the following restrictions: \_\_\_\_\_
- should not participate in sports

.....  
 Health Care Provider's Signature Date

MD  NP  PA

.....  
 Health Care Provider's Name (please print)

.....  
 Address City State Zip Code

.....  
 Phone Number Fax Number

