

PLEASE NOTE

ALL STUDENTS are required to return the **completed** HEALTH and IMMUNIZATION REPORT prior to registration. Any student failing to provide this required documentation will be prohibited from registering and attending classes. This form must be completed in **ENGLISH**.

HEALTH REPORT

Brandeis University

Health Center
A CareGroup Facility
415 South Street MS 034
Waltham, MA 02454-9110
Telephone (781) 736-3677

**FOR HEALTH SERVICES
USE ONLY**

ALLERGIES:

Date Received: _____
Measles: #1 #2
Mumps: Rubella:
Tetanus:
Hepatitis B
PPD CXR INH
Meningococcal
Physical Exam Labs
Complete: Exemption

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

Permanent Address: _____ Soc. Sec. #: _____
street

_____ Birthplace (Country): _____
City State Zip Country

Home Telephone: _____ (____) _____ Email address: _____
Country Code if International Area Code

Father's Name: _____ Mother's Name: _____

Father's Home Phone: _____ (____) _____ Mother's Home Phone: _____ (____) _____

Father's Profession: _____ Mother's Profession: _____

Father's Business Phone: _____ (____) _____ Mother's Business Phone: _____ (____) _____

Date entering Brandeis University: _____ Status: Undergraduate Graduate Cont. Ed. ELI

Transfer College(s) attended: _____ Dates attended: _____

Alternate Emergency Contact:

Name: _____ Relationship _____
Last First

Address: _____
Street City State Zip Country

Home Telephone: _____ (____) _____ Business Telephone: _____ (____) _____

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 child,
_____,
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.

Parent/Guardian's name (please print) _____ Relationship _____

Signature _____ Date _____

CONSENT FOR TREATMENT

To be signed by student over 18 years of age:

I consent to care at the university Health Center.

Signature _____ Date _____

MEDICAL HISTORY

FAMILY HISTORY

To be filled out by Applicant

	Age	State of Health	Age at Death	Cause of Death	Have any of your immediate relatives had any of the following:		
					Yes	Relationship	
Father					Alcoholism		
Mother					Asthma or Allergies		
Brothers					Blood or Bleeding Disorder		
					Cancer		
Sisters					Diabetes		
					Heart Disease		
Spouse					High Blood Pressure		
Children					Kidney Disease		
					Mental Illness		
					Seizure Disorder		
					Tuberculosis		

PERSONAL HISTORY

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

- | | | | |
|--|--|--|--|
| 1. <input type="checkbox"/> Abnormal Pap | 11. <input type="checkbox"/> Diabetes | 21. <input type="checkbox"/> Impaired mobility/paralysis | 31. <input type="checkbox"/> Phlebitis/deep vein clot |
| 2. <input type="checkbox"/> Anemia/Bleeding Disorder | 12. <input type="checkbox"/> Frequent Ear problems | 22. <input type="checkbox"/> Irregular Heartbeat | 32. <input type="checkbox"/> Pneumothorax |
| 3. <input type="checkbox"/> Anorexia Nervosa/Bulimia | 13. <input type="checkbox"/> Eye problem | 23. <input type="checkbox"/> Irritable Bowel Syndrome | 33. <input type="checkbox"/> Positive TB test |
| 4. <input type="checkbox"/> Appendectomy | 14. <input type="checkbox"/> Fainting | 24. <input type="checkbox"/> Kidney stone | 34. <input type="checkbox"/> Rheumatic fever |
| 5. <input type="checkbox"/> Arthritis | 15. <input type="checkbox"/> Severe Head injury | 25. <input type="checkbox"/> Kidney disease/Urinary Infect | 35. <input type="checkbox"/> Seizure disorder |
| 6. <input type="checkbox"/> Asthma | 16. <input type="checkbox"/> Heart murmur/click | 26. <input type="checkbox"/> Learning disability | 36. <input type="checkbox"/> Sickle cell disease/trait |
| 7. <input type="checkbox"/> Bone or Joint Problem | 17. <input type="checkbox"/> Heart disease/problem | 27. <input type="checkbox"/> Malaria | 37. <input type="checkbox"/> Testicular Problem |
| 8. <input type="checkbox"/> Cancer/malignancy | 18. <input type="checkbox"/> Hepatitis/Jaundice | 28. <input type="checkbox"/> Recurrent Headache | 38. <input type="checkbox"/> Thyroid disease |
| 9. <input type="checkbox"/> Chickenpox | 19. <input type="checkbox"/> High blood pressure | 29. <input type="checkbox"/> Mononucleosis | 39. <input type="checkbox"/> Tuberculosis |
| 10. <input type="checkbox"/> Colitis/Ileitis | 20. <input type="checkbox"/> HIV infection | 30. <input type="checkbox"/> Neuro-muscular disease | 40. <input type="checkbox"/> Ulcer |
| | | | 41. <input type="checkbox"/> Other serious illness or injury |

GYNECOLOGICAL HISTORY (check all that apply)

Age at onset of menses _____ Length of cycle _____ Date last PAP Smear _____ Result: _____

Have you ever had colposcopy? _____ Date _____ Irregular periods/no periods Painful cramps
 Breast lumps/Fibrocystic Disease

Explain all positive answers with dates: _____

MAJOR ILLNESS, OPERATIONS OR HOSPITALIZATIONS: If any, provide details including dates, diagnoses, surgeries, etc.

ALLERGIES: Please specify, including medications, insect venom, foods, etc. _____

- Do you smoke? Yes No How many cigarettes a day? _____ For how many years? _____
- Do you drink alcohol? Yes No How often? _____ If you drink, how many drinks do you have on the average in one evening?
- Are you concerned about your own, a friend's or family member's drinking or drug use? Yes No
- Do you exercise? Yes No What type? _____ How often? _____
- When you travel in a car, what % of the time do you wear a seatbelt? _____%
- Do you wear a helmet when biking/roller blading? Yes No
- Do you examine your breasts/testicles regularly? Yes No
- Do you follow any special diet? Yes No What kind? _____
- Are you concerned about your eating patterns? Yes No Your weight? Yes No
- Do you consider yourself underweight overweight normal weight
- Have you ever received treatment or counseling for an emotional problem? Yes No Dates of treatment: _____

IMMUNIZATION RECORD

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, Brandeis University requires verification of immunity for all required immunizations.

Student's Name _____ /_____/_____
Last First M.I. Date of Birth

I. REQUIRED IMMUNIZATIONS

MMR (MEASLES, MUMPS, RUBELLA) 2 doses required

- | | | | | |
|---|--------|-------|-------|-------|
| <input type="checkbox"/> Dose 1 Immunized on or after first birthday | Dose 1 | _____ | _____ | _____ |
| <input type="checkbox"/> Dose 2 Given at least one month after Dose 1 | Dose 2 | _____ | _____ | _____ |

If unable to document Measles, Mumps and/or Rubella immunization dates, you must have titers. This is a blood test to prove you are immune. A copy of the lab report with the value in English is required.

TETANUS-DIPHTHERIA

- | | | | | |
|---|-------|-------|-------|-------|
| <input type="checkbox"/> Completed primary series of tetanus-diphtheria immunizations | Date: | _____ | _____ | _____ |
| <input type="checkbox"/> Received tetanus-diphtheria booster within last 10 years | Date: | _____ | _____ | _____ |

MENINGOCOCCAL VACCINE (May be waived by signing the attached form) Date _____

HEPATITIS B VACCINE Dose 1 _____ Dose 2 _____ Dose 3 _____
Month Day Year Month Day Year Month Day Year

II. RECOMMENDED

TUBERCULOSIS SCREENING

Date and test results required. BCG Vaccine is not a contraindication to testing.

- | | | | | | | |
|--|---|-----------------------------------|-------|-------|-------|-------|
| <input type="checkbox"/> PPD (Mantoux) test within the past 6 months. Indurations ____mm | <input type="checkbox"/> Negative | <input type="checkbox"/> Positive | Date: | _____ | _____ | _____ |
| <input type="checkbox"/> Chest x-ray (in the past 6 months if positive PPD) | Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive | | Date: | _____ | _____ | _____ |
| Chest x-ray reports must be in ENGLISH. | | | | | | |
| <input type="checkbox"/> If positive PPD, treatment with _____ | | | Date: | _____ | _____ | _____ |

Please provide dates of the below vaccines

Hepatitis A Vaccine	Dose 1 _____	_____	Dose 2 _____	_____	
	Month Year		Month Year		
Varicella Vaccine	Dose 1 _____	_____	Dose 2 _____	_____	or Date of disease _____
	Month Year		Month Year		Year
Polio Vaccine	Dose 1 _____	_____	Dose 2 _____	Dose 3 _____	Dose 4 _____
	Month Year		Year	Year	Year

MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER

Name _____ MD, NP, PA, DO (not a Parent Clinician)

Signature _____ Telephone (____) _____

PHYSICAL EXAMINATION

(Must be completed within the past six months)

Student's Name: _____ Date of Exam: _____

Height _____ Weight _____ BP _____ Pulse _____ Hearing: Right _____ Left _____

If you plan to participate in varsity athletics this physical exam should serve as a pre-participation sports physical

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

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Lungs/Chest		
Breasts		
Heart/Vascular System		
Abdomen (rectal if indicated)		
Genito-urinary		
Pelvic (if indicated)		
Lymphatic		
Musculo-skeletal		
Neurological		
Endocrine		
Psychological		
Lab work: Hgb/Hct _____ Cholesterol _____ Urine: Glucose: _____ Protein _____ Micro _____		

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.

Additional comments and recommendations: _____

Please list any special **DIETARY REQUIREMENTS:** _____

Please list all **ALLERGIES** (including medications, insect venom, etc.): _____

Type of reaction _____

Please list all **MEDICATIONS** currently being taken (include Vitamins, Over the Counter Medication, Contraceptives, Inhalers, Epi-Pens, Allergy injections): _____

Recommendations for physical activity and/or sports participation: unlimited limited (specify)

Health Care Provider (please print) _____

Address _____

Phone (____) _____ FAX (____) _____

Provider's Signature: _____

Mail completed form to:
Brandeis University
 Health Center
 A CareGroup Facility
 415 South Street MS 034
 Waltham, MA 02454-9110
 Telephone (781)736-3677

Information about Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and 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 is at most risk for 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. People who live in settings such as college dormitories are also at greater risk of infection.

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 2 vaccines available that protect against 4 of the most common of the 13 serogroups (subgroups) of *N. meningitidis* that cause serious disease. Meningococcal polysaccharide vaccine is approved for use in those 2 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 in 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 to 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. **(See reverse side)**

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 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. Beginning in August 2005, all new students at these institutions must provide documentation of having received meningococcal vaccine (within the last 5 years) at least 2 weeks prior to the beginning of classes, unless they qualify 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, 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
- 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 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.

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 or SSN: _____

Signature: _____ Date: _____

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

Provided by:

Massachusetts Department of Public Health / Division of Epidemiology and Immunization / 617-983-6800

MDPH Meningococcal Information and Waiver Form March 2005