HEALTH REPORT

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**.

Brandeis University
Health Center

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: #1 #2 #3
Meningococcal:
PPD risk: low high
Results: neg pos
CXR: INH:
Varicella: disease vaccine
Physical Exam:
Complete: Exemption:

Name: ______________________________________ Gender____________ Date of Birth: ______________________
Last First MI Month Day Year

Permanent Address: ____ Sage ID #: ____________________
street (if known)

____ Birthplace (Country): ________________
City State Zip Country

Home Telephone:________ (_____)____________________________ Cell Phone: (____)______________________________
Country Code if International Area Code

Date entering Brandeis University: ________________________ Email address: _________________________________

Transfer College(s) attended: ______________________________ Dates attended: ________________________________

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: _____(_____)______________________

Alternate Emergency Contact:
Name: ____
Last First Relationship
Address: ____
Street City State Zip Country
Home Telephone :_________(_____) ________________________________ Business Telephone :______(_____) ____________________

CONSENT FOR EMERGENCY TREATMENT

To be signed by parent/guardian if student is under l8 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.

____
Relationship to Student Signature Date

CONSENT FOR TREATMENT

To be signed by student over l8 years of age:

____
Student Signature Date

INSURANCE

As noted on the "STUDENT" letter, the MA law states, "Insurance must be reported each year". Brandeis requires filing directly in SAGE. If you have private insurance please send a copy of both sides of the insurance ID card when you return this form.

MEDICAL HISTORY

To be filled out by Student

FAMILY HISTORY

	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 / Drug Issues		
Mother					Blood Clots or Bleeding Disorder		
Brothers					Cancer		
					Diabetes		
					Heart Disease		
Sisters					High Blood Pressure		
					Kidney Disease		
					Mental Illness/Suicide (or Attempts)		
Spouse					Seizure Disorder		
Children					Tuberculosis		

PERSONAL HISTORY

Check the box if you have had any of the following:

Absence of Paired Organ (eye, ear, kidney, testicle)
ADD/ADHD
Alcohol/drug issues
Allergies: seasonal or environmental
Anemia /bleeding disorder
Anxiety
Appendectomy
Arthritis
Asthma
Back pain
Bipolar illness
Blindness/visual impairment
Blood clots
Breast disease or lumps
Cancer/malignancy
Chickenpox
Chronic fatigue syndrome
Chronic lung disease
Cigarette smoking
Colitis/ileitis
Concussion/ serious head injury
contraception
counseling
Deafness/hearing impairment
Depression
Diabetes
Eating disorder

Emotional/mental illness
Endometriosis
Fainting /loss of consciousness
Gastritis/GERD
Genital herpes (HSV)
Gynecological issue/ abnormal Pap
Heart murmur/click
Heart disease/problem
Hepatitis
Herpes
High blood pressure
High cholesterol
HIV infection/disease
Hives
HPV (Human Papilloma Virus)
Impaired Mobility/Paralysis
Inflammatory bowel disease (colitis or Crohn's)
Irritable bowel syndrome
Irregular heart beat
Irregular Menstrual Cycle/No periods
Kidney Disease
Kidney stones
Learning disability
Liver disease /jaundice
Malaria
Meningitis
Migraines/chronic headaches

Mononucleosis
Neuromuscular disease
Overweight/obesity
Panic attacks
Painful cramps
Pelvic inflammatory disease
Phlebitis/ deep vein clot
Pneumothorax
Positive TB test
Rheumatic fever
Seizure disorder
Sexually transmitted infection (STI)
Sickle Cell Disease /trait
Skin Conditions
Sleep disorder/ insomnia
Stroke
Testicular problem
TB/ tuberculosis
Thyroid disease
Ulcer/stomach problems
UTIs (frequent/recurrent)
Warts
Weight gain /loss (recent)
Other

No significant past medical history

Please give details of any you have checked (attach additional pages if necessary): __________________________

Hospitalizations, major injuries, major illness, operation: __________________________

Medications (Include prescription, over the counter, and herbal medicines): __________________________

Allergies (Medication, Food or Insect Stings): __________________________

Brandeis University Health Center
415 South Street MS 034
Waltham, MA 02454

IMMUNIZATION RECORD

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, and Department of Public Health Regulations 105 CMR 220, Brandeis University requires verification of immunity for all mandated immunizations.

Student's Name____ ______/_____/_____
Last First M.I. **Date of Birth**

I. MANDATORY IMMUNIZATIONS

Please record doses given only, NOT anticipated dates of next doses.

MMR (MEASLES, MUMPS, RUBELLA) 2 doses required

			Month	Day	Year
Dose 1	Immunized on or after first birthday	Dose 1	_____	_____	_____
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

		Month	Day	Year
Completed primary series of tetanus-diphtheria immunizations	Date:	_____	_____	_____
Received tetanus-diphtheria booster within last 10 years	Date:	_____	_____	_____

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

If unable to document Hepatitis B immunization dates, you must have a titer. This is a blood test to prove you are immune. A copy of the lab report with the value in English is required.

MENINGOCOCCAL VACCINE within 5 years Date: ______ _____ ______
(May be waived by signing the attached form)

TUBERCULOSIS SCREENING: All students must complete the attached **Tuberculosis Risk Questionnaire**.

II. RECOMMENDED

If the student has received these vaccines, please provide dates below:

Hepatitis A Vaccine Dose 1 ______ ______ (Month Year) Dose 2 _____ ______ (Month Year)

Varicella Vaccine Dose 1 ______ _____ (Month Year) Dose 2 _____ _____ (Month Year) or Date of disease ___________ (Year)

Polio Vaccine Dose 1 ______ _____ (Month Year) Dose 2 _____ (Year) Dose 3 _____ (Year) Dose 4 _____ (Year)

HPV Vaccine Dose 1 ______ _____ (Month Year) Dose 2 _____ _____ (Month Year) Dose 3 _____ ______ (Month Year)

MUST BE VERIFIED BY A LICENSED HEALTH CARE PROVIDER

Name ____________________________________ MD, NP, PA, DO (not a Parent Clinician) Date ________________

Signature____________________________________ Telephone (___) ________________________________

PHYSICAL EXAMINATION

(Must be completed within the past six months)

Student's Name: ___________________________________ **Date of Exam:** _____________ **Date of Birth:** ______________

Height_________ Weight_________ BP ___________ Pulse ______________ Vision test: OD______ OS______ OU______

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		

Recommended
Lab work: Hgb/Hct ____________ Cholesterol __________ Urine: Glucose: ______ Protein _______ Micro ______

CURRENT AND CHRONIC 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.

SPECIAL DIETARY REQUIREMENTS: ____

CURRENT MEDICATIONS (include Vitamins, Over the Counter Medication, Contraceptives, Inhalers, and Epi-Pens):

____

ALLERGIES to Medications: _____________________________________**Type of Reaction:** __________________________________

_____________________________________ __________________________________

Allergies to Other Things: _______________________________________ **Type of Reaction:** __________________________________

Has an Epi-pen been prescribed? _________________________

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

____

Health Care Provider (please print) ____

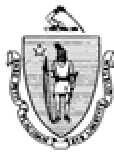
Address____

Phone (_____)_________________________________FAX (_____)______________________

Provider's Signature:____

Mail completed form to:

Brandeis University
Health Center
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

Revised legislation in Massachusetts now requires all newly enrolled full-time students attending a secondary school (e.g., boarding schools) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to:

1. receive meningococcal vaccine; or
2. fall within one of the exemptions in the law, which are 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 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 US, about 1,000-3,000 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, 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 or sneezing.

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 and meningococcal conjugate vaccine is approved for use in those 2-55 years of age. 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 either vaccine. Protection 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. 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.

A few cases of Guillain-Barré syndrome (GBS), a rare but serious nervous system disorder, have been reported among people who received meningococcal conjugate vaccine. This information is still being evaluated by health officials. An ongoing risk of serious meningococcal disease exists. At this time, experts continue to recommend vaccination for those at increased risk of acquiring meningococcal disease. However, persons who have had GBS should generally not receive meningococcal conjugate vaccine, and should talk to their doctor about their other options for vaccination.

Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or colleges that provide or license housing?
Massachusetts law (MGL Ch. 76, s.15D) requires newly enrolled full-time students attending a secondary school (those schools with grades 9-12) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to receive 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. All students covered by the regulations must provide documentation of having received a dose of meningococcal polysaccharide vaccine within the last 5 years (or a dose of meningococcal conjugate vaccine at any time in the past), unless they qualify for one of the exemptions allowed by the law. 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.

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 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 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/imm and http://www.mass.gov/epi
- 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 newly enrolled full-time students at secondary schools, colleges and universities who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school or postsecondary institution 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

Brandeis University

TUBERCULOSIS RISK QUESTIONNAIRE
Must be completed by all students and returned with Health Report

Name: ____ Date of Birth: ______________________

Country of Birth: ____________________

	YES	NO
1. Have you ever had a positive tuberculosis skin test? (If yes go to Page 2)	❑	❑
2. To the best of your knowledge, have you had close contact with anyone who was sick with Tuberculosis (TB)?	❑	❑
3. Were you born in one of the countries listed below?	❑	❑
4. Have you traveled or lived for more than one month in any of the countries listed below?	❑	❑

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

* World Health Organization. Global Tuberculosis Control. WHO report 2008.

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

HIGH RISK: If the answer to question 2, 3 or 4 is YES, Brandeis University requires that you have a tuberculin skin test (Mantoux test) to check for latent tuberculosis infection. **YOUR HEALTHCARE PROVIDER MUST COMPLETE THE FORM ON THE BACK OF THIS PAGE**

LOW RISK: If the answer to all of the above questions is NO, a tuberculin skin test should not be done.

Brandeis University

Medical Evaluation for Latent Tuberculosis Infection

(To be completed and signed by a licensed healthcare provider)

Name: ____ Date of Birth: _____ / _____ /_____

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

A. TUBERCULIN SKIN TEST (Mantoux)

Test must be read by a healthcare provider 48-72 hours after administration. If no induration, indicate “0 mm”.
Result of multiple puncture tests, such as Tine or Mono-Vac, are NOT accepted.
Date administered: ___ / ___ / ___ Date test read: ___ / ___ / ___ Result ______ mm of induration.

Interpretation of Tuberculin skin test	
RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born to a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country that has a high rate of Tuberculosis	10 mm or more
No risk factors (test not recommended)	15 mm or more

B. If Tuberculin Skin Test is POSITIVE, now or by history, the following are required:

1. Date of positive PPD: Date: ____ / ____ / ____
   Month Day Year
2. Chest X-ray: Required (attach report, NOT the X-ray) Date: ____ / ____ / ____
   Month Day Year

❑ Normal ❑ Abnormal ____ (Describe)

3. Clinical Evaluation:

❑ Normal ❑ Abnormal ____ (Describe)

4. Treatment:

❑ No ❑ Yes ____ (Drug, dose, frequency and dates)

HEALTHCARE PROVIDER SIGNATURE: (Required) __________________________________ DATE: ____ / ____ / ____
Month Day Year

Phone: ____ Fax: _____________________________________