

HEALTH HISTORY & IMMUNIZATION FORM

****Deadline to return this form is August 1st****

Suffolk University Health & Wellness Services
Tel: (617) 573-8260 Fax: (617) 305-1745

Mailing Address:
8 Ashburton Place
Boston, Massachusetts 02108

Office Location:
73 Tremont Street
5th Floor

Name: _____ Today's Date: _____

Phone # (where student can be contacted) _____ Email: _____

Student ID#: _____ Birth Date: _____ Age: _____

Permanent Address: _____
Street City/town State/Zip code

Emergency Contact Information*: Name: _____ Relationship: _____

Phone # : Home: _____ Office: _____ Cell: _____

Address: _____
Street City/town State/Zip

**By providing this information you are giving Health & Wellness Services permission to contact this person in an emergency situation in which you are unable to contact the person yourself.*

Health Insurance

All students enrolled in nine or more credits are required to have health insurance and therefore are automatically enrolled in the Suffolk Student Health Insurance Plan (SSHIP). If, while enrolled at Suffolk, you are already covered under an existing insurance policy you can waive SSHIP enrollment online at www.universityhealthplans.com. This waiver must be submitted no later than September 25th and must be renewed every year. ***All international students are required to participate in SSHIP regardless of course credit load.***

Insurance Information: _____
Insurance Company

Policy Number: _____ **Group Number:** _____

Address: _____
Street City/Town State, Zip Code

Insurance Phone Number: (_____) _____.

IMPORTANT: The insurance information provided above **DOES NOT** waive your SSHIP enrollment. As instructed above, you must complete the online waiver form at www.universityhealthplans.com **NO LATER THAN SEPTEMBER 25th**.

Immunization Record

****NOTE: Immunization requirements are listed on page 5****

This immunization form **must be signed by a licensed medical provider**; it will not be accepted without the provider's signature, address and telephone number. Incomplete forms will NOT be accepted.

Substitute forms may be acceptable, i.e., school records, Doctor's office records, etc.

Required immunizations for ALL students:

Immunization	Date Received
Measles #1:	___/___/___
Measles #2:	___/___/___
Mumps:	___/___/___
Rubella:	___/___/___
Tetanus/Diphtheria:	___/___/___
Hepatitis B #1:	___/___/___
Hepatitis B #2:	___/___/___
Hepatitis B #3:	___/___/___

OR

Immunization	Date Received
MMR #1:	___/___/___
MMR #2:	___/___/___

Required immunizations for students living in a RESIDENCE HALL:

Immunization	Date Received
Meningitis:	___/___/___

OR

_____ I have enclosed a **signed** waiver (found at: <http://www.suffolk.edu/offices/2624.html>) stating that I do not wish to receive the meningitis vaccine. (The signed waiver must accompany this form.)

Recommended immunizations:

<p>Varicella (chickenpox): ___/___/___ or history of the disease? YES / NO</p> <p>Tuberculosis (TB): <i>**Please read enclosed tuberculosis risk questionnaire.</i></p> <p>Are you a high risk individual? YES / NO</p> <p><i>If you answered YES it is recommended that you have a TB skin test (PPD). Please have your health care provider complete the information below:</i></p> <p>TB skin test: ___/___/___ Date Read: ___/___/___ Result: _____mm</p> <p>Chest X-ray: ___/___/___ Result: _____</p>
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Other immunizations received:

Immunization	Dose	Date Received
		___/___/___
		___/___/___
		___/___/___
		___/___/___

Provider Signature: _____

Provider Address: _____

Provider Name (print): _____

Telephone Number: _____

Medical History/Family Medical History

Do you have any serious medical conditions? **YES / NO** If yes, please describe: _____

Do you wear a medical alert bracelet or necklace for this condition? **YES / NO**

NOTE: If you plan on residing in one of the residence halls you **MUST** wear a medical alert bracelet or necklace if you have a serious medical condition. Failure to do so may result in loss of campus housing.

Please check if you or your family has/had any of the following:

Medical History	Student	Mother	Father	Siblings	Mother's mother	Mother's father	Father's mother	Father's father
Frequent headache or migraine								
Epilepsy or Seizure disorder								
High cholesterol								
High blood pressure								
Heart condition or heart attack								
Blood clots, stroke								
Lung disease, asthma								
Jaundice, liver problems								
Stomach, bowel, or gallbladder problems								
Breast problems								
Sexually transmitted infections, including herpes and warts								
Cancer								
Diabetes								
Thyroid problems								
Anemia or blood disorders, including sickle cell disease								
Mononucleosis								
Birth or inherited diseases, including cystic fibrosis								
Drug dependency								
Allergies (environmental or food)								
Kidney disease								
Learning disability								
Alcoholism								
Neurological disease								
Mental or nervous problems (i.e. depression, anxiety)								

Explanation (of any boxes checked above): _____

If you answered YES to any of the above questions, the Massachusetts Department of Public Health strongly recommends that you have a tuberculin skin test.

If you answered NO to all of the above questions, a tuberculin skin test should not be done.

Immunization Requirements

Massachusetts State Law requires that all **FULL TIME** students taking 12 or more credits (including undergraduate, graduate, and law students) must have the following immunizations:

Immunization	Dose	Dose Requirement
*Measles	2	On or after 1 st birthday; 1 st and 2 nd dose must be at least 1 month apart
*Mumps	1	On or after 1 st birthday
*Rubella	1	On or after 1 st birthday
***Tetanus/Diphtheria	1	Within the last 10 years
Hepatitis B	3	1 st and 2 nd dose 1 month apart; 2 nd and 3 rd doses at least 2 months apart, preferably 4 months apart
* 2 MMR immunizations may be substituted, given on or after 1st birthday; 1st and 2nd dose must be at least 1 month apart		
**Meningitis	1	Within the last 5 years (Only students living in a RESIDENCE HALL are required to have this immunization)
<i>** Students may sign a Meningitis waiver (found at: http://www.suffolk.edu/offices/2624.html) stating that they have been made aware of the dangers of Meningitis but have elected to decline the vaccination.</i>		

*If you are unable to provide documentation of your immunization records, you can have a titer drawn showing that you are immune to Measles, Mumps and Rubella and Hepatitis B. A copy of the titer lab report showing that you are immune must be submitted as an attachment with this form. ***You CANNOT get a titer for the Tetanus/Diphtheria, you must have this immunization.*



SUFFOLK UNIVERSITY HEALTH & WELLNESS SERVICES



CONSENT FOR TREATMENT

The following Consent for Treatment is to be carefully reviewed & then signed by the student and/or a legally authorized parent/guardian.

I consent to treatment by Suffolk University Health & Wellness staff while I am enrolled at Suffolk University. I understand that there is no charge to be examined by a provider at Suffolk University Health & Wellness Services. However, I also understand that I and/or my insurance plan may incur charges for additional medical services including (but not limited to) lab tests, radiology tests, and vaccines.

I understand that Suffolk University Health & Wellness Services, in certain instances, may disclose my health records without my permission as authorized by federal and/or state law. I understand that, upon enrollment, Suffolk University Health & Wellness Services will make additional information available to me in its department located at 73 Tremont Street 5th floor, Boston, MA 02108 and on its website www.suffolk.edu/healthservices.

Student Name (please print): _____ **Student D.O.B.:** _____ **Suffolk ID:** _____

Student Signature: _____ **Date:** _____

Parent/Guardian Name: *required for students <18 years of age* (please print): _____

Parent/Guardian Signature: *required for students <18 years of age* _____

If you have questions about this Consent for Treatment please contact Suffolk University Health & Wellness Services for assistance at:

73 Tremont Street, 5th floor, Boston, MA 02108
Tel: 617.573.8260 Fax: 617.305.1745 Email: health@suffolk.edu