Suffolk University Health Services
73 Tremont Street, 5th Floor
Boston, Massachusetts 02108
Tel: (617) 573-8260
Fax: (617) 305-1745

Name: _____D.O.B._____

Entering Suffolk University as: **Freshman / Transfer / Graduate / Law School** (Circle One)

Will you be living: (Circle One)

On Campus (150 Tremont or 10 Somerset) / Off-campus in an apartment / At home

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 either 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 can result in loss of campus housing.

Permanent Address: _____
Street City/Town State, Zip Code

Emergency Contact Information: _____
Name Relationship

Phone Number: (____)_____(____)_____(_____)_____
Home Office Cell

Address: _____
Street City/Town State, Zip Code

In the case of a medical emergency the above-mentioned individual will be contacted. By providing this information you are giving Health Services permission to contact them in a true emergency situation where you are unable to contact them yourself. You may be requested to provide similar information to the Residence Life office. Due to confidentiality issues you must provide **both** the Residence Life office and Health Services this information. There will be no exchanging of emergency contact information between the two offices. **This information will ONLY be used in times of a true medical emergency and will not be used in any other circumstances without your written approval.**

Insurance Information: _____
Insurance Company

Policy Number: _____ Group Number:_____

Address: _____
Street City/Town State, Zip Code

Phone Number: (_____)_____.

All students enrolled in nine or more credits MUST have Health Insurance. If you are not covered under a family members insurance policy you MUST take the school sponsored policy. ***ALL International Students, regardless of the number of credits you are taking, MUST take the school sponsored policy.

To enroll or waive the school's insurance policy you MUST go to the website www.universityhealthplans.com. The information provided above DOES NOT waive you from the insurance; you must do this on-line, this is solely for the use of Health Services. The deadline for the Fall semester is September 30th and for the Spring Semester is February 15th. If you are entering in the Fall you only have to waive or enroll in the Fall. The Spring enrollment is just for students entering in the Spring. This enrollment/waiver process MUST be done every year that you attend Suffolk.

Immunization Requirements: *Massachusetts State Law requires that **all students**, regardless of the number of credits they are taking must either have a meningococcal vaccine within the last five years or sign a waiver stating that they have been made aware of the dangers of Meningitis but have elected to decline the vaccination.* Massachusetts State Law states that all students taking 12 or more credits must have the following immunizations, this includes undergraduates, graduate and law school students:

2 doses of the Measles vaccine, these must have been on or after your first birthday

1 dose of the Mumps vaccine and 1 dose of Rubella. These must have been done on or after your first birthday.

A Tetanus/diphtheria shot within the last ten years. This will need to be maintained throughout your years at Suffolk. Should your Td become outdated you will be notified that you must be re-immunized to remain compliant with the immunization requirements

3 doses of Hepatitis B, the 1st and 2nd dose should be 1 month apart and the 2nd and 3rd dose MUST be at least two months apart.

Your immunization records can be obtained at your pediatrician's office, high school, or undergraduate college or university. If you are unable to get any of your records, you can have a titer drawn showing that you are immune to the Measles, Mumps and Rubella and Hepatitis B, **a copy of the lab report showing that you are immune must be submitted with this form**. You CANNOT get a titer for the Tetanus/Diphtheria. You must have the immunization.

The 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.

Measles #1: ____/_____/_____ or MMR #1: _____/_____/_____
Measles #2: ____/_____/_____ MMR #2: _____/_____/_____
Mumps: _____/_____/_____
Rubella: _____/_____/_____

*First dose MUST be on or after 1st birthday.
*Second dose must be at least 1 month after 1st dose.

Tetanus/Diphtheria: _____/_____/_____ d.
*Must be within the last 10 years

Meningococcal Vaccine: ____/_____/_____
*Must be within the last 5 years
or check if you have enclosed a waiver stating that you do not wish to receive the vaccine _____. Waiver must accompany this form.

Hepatitis B #1 _____/_____/_____ 1st and 2nd dose should be at least one
Hepatitis B #2 _____/_____/_____ month apart and dose #2 and #3
Hepatitis B #3 _____/_____/_____ **must** be at least two months apart.

Recommended Vaccinations:

Varicella (chickenpox): _____/_____/_____ or history of the disease? **YES /NO**

Tuberculosis Skin Test **please read the enclosed tuberculosis risk questionnaire**.

Are you a high risk individual? Yes____ No____. If you answered yes it is recommended that you have a tuberculosis skin test, a PPD. Please have your health care provider complete the information below.

TB skin test: ____/_____/____ Date Read_____/_____/_____Result: _____mm

Chest X-ray: _____/_____/_____ Result

Signature of Provider: _____ Printed name of Provider: _____

Address of Provider: _____ Telephone Number: _____

_____

_____

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

Medical History

Have you ever had any surgeries or operations? Please list with date: _____
_____
_____

Have you ever been hospitalized for any reason? If yes please list the reason and the date of the hospitalization. If hospitalized for the same condition a number of times please give the number of hospitalizations for that condition:_____
_____
_____

Do you are any medical conditions that require daily medications? Please list with name and dosage of medication:_____
_____
_____

Are you currently on any medications? Please list with the name and dosage:_____
_____
_____

Do you have any allergies? If so, please list:_____
_____

Personal Medical History, please circle all conditions that you have been diagnosed with or currently have:

Asthma High Blood Pressure Eating Disorder Learning Disability
Thyroid Disease Diabetes (insulin dependant) Diabetes (non-insulin dependant)
Liver Disease Kidney Disease Cancer Sickle Cell Anemia Alcoholism
Drug dependency Blood Disease Gastro-intestinal disease
Environmental Allergies Food Allergies Neurological Disease Cardiac Disease
Epilepsy or Seizure Disorder Mental Illness Depression Anxiety Cystic Fibrosis

If you circled any of the above, please describe current condition of this illness, ie., remission, currently active, controlled via medication, in therapy etc.,:_____
_____
_____

Family History: Please list parents and siblings current age, current health, any medical conditions. If parent or sibling is deceased please list age of death and cause of death.

Father: _____
_____

Mother:_____
_____

Siblings:_____
_____