HEALTH HISTORY & IMMUNIZATION FORM

Please return by August 1st

Suffolk University Health 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:____________

School Address:____
Street City/town State/Zip code

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

Emergency Contact Information: Name: _____________________________ Relationship: ________________

Phone # : 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 the times of a true medical emergency and will not be used in any other circumstances without your written approval.***

Health Insurance

All students enrolled in nine or more credits MUST have Health Insurance. If you are not covered under a family member's insurance policy you MUST take the school sponsored policy.
All international students must participate in the university sponsored health insurance plan.

Insurance Information: ____
Insurance Company

Policy Number: ___________________________ **Group Number**:__________________

Address: ____
Street City/Town State, Zip Code

Insurance Phone Number: (_____)__________________.

***The information provided above **DOES NOT** waive you from the school sponsored health insurance; you must complete the online waiver form.*
To enroll in or waive the school's insurance policy you MUST go to the website www.universityhealthplans.com.

Immunization Record

NOTE: Immunization requirements are listed on page 4*

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.

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 waiver stating that I do not wish to receive the meningitis vaccine. (Waiver must accompany this form)

Recommended immunizations:

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

Tuberculosis (TB): ***Please read enclosed tuberculosis risk questionnaire.*

Are you a high risk individual? **YES / NO**
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:

TB skin test: ___/___/___ Date Read:____/___/___ Result: _____mm
Chest X-ray: ___/___/___ Result: ______________

Other immunizations received:

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

Provider Signature: ___________________________ Provider Name (print):__________________________
Provider Address: ___________________________ Telephone Number: _______________
____

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

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):
____
____

Have you ever been hospitalized or had any surgeries? **YES / NO**
Explain: ____

Do you have any medical problems not mentioned? **YES / NO**

Explain:____

Allergies to medications: ____

Medications currently taking (including birth control pills, over the counter medications):

1. ____________________________ 4. ____________________________
2. ____________________________ 5. ____________________________
3. ____________________________ 6. ____________________________

Health Habits:

Smoking: Y N How many?________ How many years?:________________________

Drinking: Y N How much? ________ How often?: ____________________________

Drug use (including marijuana): Y N Type: ______________________ How often:______________

Do you have concerns about your use of drugs or alcohol? Y N

Exercise: More than 3x/week: _________ Weekly: __________ Rarely: __________

Eating habits: Excellent: _________ Fair: __________ Unhealthy: ________

Do you ever make yourself vomit after eating? Y N Do you ever restrict your eating? Y N

Have you ever had a history of anorexia/bulimia? Y N

Tuberculosis (TB) Risk Questionnaire

To the best of your knowledge have you ever had close contact with anyone who was sick with TB? YES NO

Were you born in one of the countries listed below? YES NO

Have you traveled or lived for more than one month in one or more of the countries listed below? YES NO

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

If you answered **YES** to **any** of the above questions, the MA 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 states that all **FULL TIME** students taking 12 or more credits must have the following immunizations, this includes undergraduates, graduate and law school students:

Immunization	Dose	Dose Requirement
*Measles	2	On or after 1st birthday; 1st and 2nd dose must be at least 1 month apart
*Mumps	1	On or after 1st birthday
*Rubella	1	On or after 1st birthday
Tetanus/Diphtheria	1	Within the last 10 years
Hepatitis B	3	1st and 2nd dose 1 month apart; 2nd and 3rd 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)
**** Students may sign a waiver stating that they have been made aware of the dangers of Meningitis but have elected to decline the vaccination***		

If you are unable to get any 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 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.*