Student Name:_____ D.O.B_____Suffolk ID_____

IMMUNIZATION, HEALTH HISTORY, & CONSENT FORM
Suffolk University Health & Wellness Services

FALL/SPRING SEMESTER DEADLINE* TO RETURN COMPLETE FORMS: **AUG 1 / JAN 31**
***IMPORTANT! Failure to submit state-required immunization documentation will result in a hold on course registration.**

Form Return Options:
- **FAX TO:** (617) 305-1745 ATTENTION: Suffolk University Health & Wellness Services
- **DROP OFF AT CLINIC:** 73 Tremont Street 5th Floor, Boston MA, 02108
- **EMAIL:** health@suffolk.edu
- **MAIL TO:** Suffolk University Health & Wellness Services, 8 Ashburton Place, Boston MA, 02108

Student Demographics:

Student Name:_____Suffolk Student ID#_____D.O.B._____

Permanent Address: _____
Street City/town State/Zip code
Student Cell Phone:_____

Emergency Contact Information:

Name: _____Relationship: _____
Phone # : Home: _____ Office: _____ Cell: _____
By providing `this information you are giving Health & Wellness Services permission to contact this person in an emergency situation if you are unable to contact this person yourself.

Health Insurance:

To comply with Massachusetts state law, all Suffolk students (domestic and international) who are enrolled in 9 credits or more per semester must have health insurance. Suffolk University's Student Health Insurance Plan (SSHIP) is a health insurance plan that meets a specific level of benefits as required by the Commonwealth of Massachusetts. If you are enrolled in 9 or more credits then you will be automatically enrolled in the Suffolk Student Health Insurance Plan (SSHIP). If you are already covered under a comparable plan you may waive* the SSHIP enrollment online at www.universityhealthplans.com.
***Your SSHIP enrollment/waiver must be submitted online at www.universityhealthplans.com no later than the current semester course registration add/drop deadline**; Failure to waive SSHIP will result in your automatic annual enrollment in SSHIP and therefore your student account will be charged the SSHIP prevailing premium. The SSHIP enrollment/waiver must be renewed every year.

Health Insurance Company: _____Policy**#:**_____**Group#**:_____

Insurance 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**.**

Student Name:_____ D.O.B_____Suffolk ID_____

Overview of Immunization Requirements
Suffolk University Health & Wellness Services

IMPORTANT!! - Failure to comply with Immunization Requirements will result in a hold on course registration.

To comply with Massachusetts State Law, Suffolk requires all students enrolled in a full time academic program must submit documentation (Immunization Record Form on pg. 3) to Suffolk Health & Wellness Services of having received the following immunizations*:

- **TDaP:** 1 dose TDaP **OR** a Tetanus-Diphtheria Booster (Td) within the past 5 years.
- **MMR:** 2 doses MMR vaccine (measles, mumps, rubella) **OR** 2 Measles, 2 Mumps and 2 Rubella. MMR Dose 1 must be after the first birthday; MMR Dose 2 must be at least one month after the 1st dose.
- **Hepatitis B:** A 3 vaccines at required intervals: 1st & 2nd dose at least 1 month apart; 2nd & 3rd doses at least 2 months apart (preferably 4 months apart).
- **Meningitis (required for students living on campus)**: 1 dose of Meningococcal Polysaccharide Vaccine within the last 5 years **OR** 1 dose of Meningococcal Conjugate Vaccine at anytime in the past.
- **Varicella:** 2 doses at least 1 month apart **OR** History of disease documented by a health care provider.

*** If you are unable to provide documentation but think you may have received these immunizations in the past you can have titers (blood test) for immunity to MMR , Hepatitis B and Varicella done. Please be aware that there is a charge for these tests that may exceed the cost of the actual vaccine.**

Student Name:_____ D.O.B_____Suffolk ID_____

Immunization Record Form

Suffolk University Health & Wellness Services

IMPORTANT: This immunization record form <u>must be signed by a licensed medical provider</u>; it will not be accepted without the provider's signature, address and telephone number. (*Supplemental forms may be acceptable, i.e., school records, Doctor's office medical records.)*

Immunization	Date Received
MMR #1	_____/_____/_____
MMR #2	_____/_____/_____

OR

Immunization	Date Received
Measles #1	_____/_____/_____
Measles #2:	_____/_____/_____
Mumps	_____/_____/_____
Rubella	_____/_____/_____

Immunization	Date Received
TDaP	_____/_____/_____

OR

Immunization	Date Received
Tetanus/Diphtheria < 5 Years	_____/_____/_____

Immunization	Date Received
Hepatitis B #1	_____/_____/_____
Hepatitis B #2	_____/_____/_____
Hepatitis B #3	_____/_____/_____

Immunization	Date Received
Varicella #1	_____/_____/_____
Varicella #2	_____/_____/_____

OR

History Of Disease	YES	NO

Immunization	Date Received
Meningitis (for students living in Suffolk housing):	_____/_____/_____

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.)

If you are unable to provide documentation of your immunization records for Measles, Mumps and Rubella, Hepatitis B, or Varicella you can have a titer drawn showing that you are immune. You must provide a copy of the titer lab report with this form.

Titer	Date	Immune	Not Immune
Hepatitis	_____/_____/_____		
Measles	_____/_____/_____		
Mumps	_____/_____/_____		
Rubella	_____/_____/_____		
Varicella	_____/_____/_____		

Provider Name (print):_____ Provider Signature:_____

Provider Address: _____Telephone Number: _____

Student Name:_____ D.O.B_____Suffolk ID_____

Tuberculosis (TB) Risk Questionnaire

Suffolk University Health & Wellness Services

1. To the best of your knowledge have you ever had close contact with anyone who was sick with TB?	YES	NO
2. Were you born in one of the countries listed below?	YES	NO
3. Have you traveled or lived for more than one month in any of the countries listed below?	YES	NO

If you answered YES to any of these questions 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: _____TB

Provider Signature: _____Provider Name (print):_____

Provider Address: _____Telephone Number:_____

Afghanistan	Chad	Guinea	Macedonia	Sudan
Angola	China	Guinea-Bissau	Madagascar	Suriname
Armenia	Colombia	Guyana	Malawi	Swaziland
Azerbaijan	Comoros	Haiti	Malaysia	Syrian Arab Republic
Bahamas	Congo (Democratic Rep)	Herzegovina	Maldives	Taiwan
Bahrain	Congo (Republic)	Honduras	Mali	Tajikistan
Bangladesh	Cote d'Ivoire	Hong Kong SAR	Marshall Islands	Tanzania UR
Belarus	Croatia	India	Mauritania	Thailand
Benin	Djibouti	Indonesia	Mauritius	Togo
Bhutan	Dominican Republic	Iran	Micronesia	Tokelau
Bolivia	Ecuador	Kazakhstan	Moldova Republic	Turkmenistan
Bosnia	El Salvador	Kenya	Mongolia	Uganda
Botswana	Equitorial Guinea	Kiribati	Morocco	Ukraine
Brazil	Eritrea	Korea	Mozambique	Uzbekistan
Brunei Dar.	Estonia	Kyrgyzstan	Myanmar	Vanuatu
Burkina Faso	Ethiopia	Laos	Namibia	Vietnam
Burundi	Gabon	Latvia	Sierra Leone	Yemen
Cambodia	Georgia	Lesotho	Solomon Islands	Zambia
Cameroon	Ghana	Liberia	Somalia	Zimbabwe
Cape Verde	Guam	Lithuania	South Africa	
Central African Republic	Guatemala	Macao SAR	Sri Lanka	

Student Name:_____ D.O.B_____Suffolk ID_____

Medical History/Family Medical History Form

Suffolk University Health & Wellness Services

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** If Yes, How many cigarettes per day or how often?_____
N If No, have you ever smoked in the past? Please Explain:_____

Drinking: **Y** If Yes, How much & how often?_____

Recreational Drug use (including marijuana): **Y** **N** Type(s): _____How often:_____

Do you have concerns about your use of smoking, 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**
If you answered Yes, please explain:_____

Have you ever had a history of anorexia/bulimia? **Y** **N**
If you answered Yes, please explain:_____

Student Name:_____ D.O.B_____Suffolk ID_____

SUFFOLK
UNIVERSITY

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 student health records without my permission as authorized by federal and/or state law. I understand that 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 Phone: _____ **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