

## COUNSELING AND HEALTH SERVICES

# Health and Immunization Form

### PART 1.

#### TO BE COMPLETED BY THE STUDENT, PARENT OR GUARDIAN

Name \_\_\_\_\_  
Last First Middle SSU Student ID Number

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_ Female \_\_\_ Transgender \_\_\_  
Month Day Year

Date Entering SSU \_\_\_\_/\_\_\_\_ Undergraduate \_\_\_ Graduate \_\_\_ Transfer \_\_\_ International \_\_\_ ESL \_\_\_  
Month Year

Permanent Address \_\_\_\_\_  
Street

City State Country ZIP

Home Telephone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

#### Emergency Contact

1. \_\_\_\_\_  
Name Home Phone Cell Phone Relationship to Student

2. \_\_\_\_\_  
Name Home Phone Cell Phone Relationship to Student

#### MEDICAL HISTORY

Do you have any health problems we should be aware of? If yes, please explain \_\_\_\_\_

Hospitalizations: Dates/diagnosis \_\_\_\_\_

Surgeries: Dates/procedure \_\_\_\_\_

Current Medications \_\_\_\_\_

Medication Allergies \_\_\_\_\_ Reaction: \_\_\_\_\_

Allergies Other \_\_\_\_\_ Do you carry an Epipen? YES \_\_\_ NO \_\_\_

Acknowledgement of receipt of privacy policy (See attached or visit [salemstate.edu/chs/new.php](http://salemstate.edu/chs/new.php))

\_\_\_\_\_  
Student/Parent/Guardian Signature

#### HEALTH INSURANCE INFORMATION OR Photocopy (2 sided) of current insurance card

Insurance Carrier \_\_\_\_\_

Policy Number \_\_\_\_\_

Group Number \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Effective Date \_\_\_\_\_

**PART 2.**

**IMMUNIZATION RECORD**

**IMMUNIZATION RECORD MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER**

*PROOF OF IMMUNIZATION IS REQUIRED BY STATE LAW TO ATTEND SALEM STATE UNIVERSITY*

Are you planning to live on campus in a residence hall? Yes \_\_\_\_ No \_\_\_\_

**A. MMR (MEASLES, MUMPS, RUBELLA): Two doses required**

- 1. Dose 1 given on or after first birthday #1 \_\_\_\_\_  
Month Day Year
- 2. Dose 2 given at least one month after first dose #2 \_\_\_\_\_  
Month Day Year

**OR**

- 3. Results of antibody titer proving immunity

**Include Copy of Results**

Date	Immune	Non Immune
Measles _____ Month Day Year	_____	_____
Mumps _____ Month Day Year	_____	_____
Rubella _____ Month Day Year	_____	_____

**B. TETANUS-DIPHThERIA-PERTUSSIS**

- 1. Tetanus-Diphtheria-Pertussis (Tdap) booster Tdap \_\_\_\_\_  
Month Day Year
- 2. Td last 10 years TD \_\_\_\_\_  
Month Day Year

**C. HEPATITIS B:**

- 1. Vaccine Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_ Dose #3 \_\_\_\_\_  
Month Day Year Month Day Year Month Day Year
- OR**
- 2. Hepatitis B surface antibody Date \_\_\_\_\_ Result: Reactive \_\_\_\_ Non-reactive \_\_\_\_  
(Include Copy of Result) Month Day Year

**D. MENINGOCOCCAL: Required for all students living in the residence halls**

- 1. Menactra Date \_\_\_\_\_ **OR** Menomune Date \_\_\_\_\_  
Month Day Year Month Day Year
- OR**
- 2. Meningococcal Vaccine Waiver Date \_\_\_\_\_  
(Waiver must be signed and attached to this form) Month Day Year

**E. VARICELLA: Titer required for nursing students**

- 1. History of Varicella (Chicken Pox) Yes \_\_\_\_ No \_\_\_\_ Date of illness \_\_\_\_\_
- 2. Varicella antibody titer Date \_\_\_\_\_ IGG \_\_\_\_\_ Pos \_\_\_\_ Neg \_\_\_\_  
\* documentation required Month Day Year Numerical Reading
- 3. Varicella vaccine (Must be given at least one month apart if immunized after age 13).  
Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Month Day Year Month Day Year

**F. TUBERCULOSIS SCREENING (PPD Skin Test) Screening is required for all incoming students.**

1. Is the student a member of a high-risk group (see below) or entering a health profession program?

The definition of high risk groups per the American College Health Association is as follows:

- **Living or working** in the past 5 years in countries where TB is endemic. This includes ALL countries **EXCEPT:** American Samoa, Australia, Belgium, Canada, Denmark, Finland, France, Germany, Greece, England, Italy, Jamaica, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, St. Kitts and Nevis, St. Lucia, Sweden, Switzerland, United Kingdom, USA, Virgin Islands, or New Zealand.
- Students with a compromised immune system: HIV infection, diabetes, chronic renal failure, leukemia, lymphoma, chronic malabsorption syndromes, prolonged steroid therapy, or other immunosuppressive disorders.
- Students **who have resided, volunteered, or worked in high-risk congregate settings:** prisons, nursing homes, hospitals, residential facilities for patients with AIDS, and homeless shelters. Use of recreational injection drugs.

\_\_\_ **NO** The student is not at high risk for TB. No further evaluation is needed

\_\_\_ **YES** The student is at high risk or needs to be screened for TB. Go to Section 2.

2. Perform PPD Skin Test within 12 months of entering Salem State University.

*Please go to Section 3 if the student has a history of a positive PPD.*

PPD Skin Test (tine or monovac not acceptable) A history of BCG vaccination does not preclude testing!

Date planted: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Date read: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_ (Record mm of induration, transverse diameter)  
Month Day Year

Interpretation: Negative \_\_\_\_\_ Positive \_\_\_\_\_ (Please complete Section 3)

3. If the PPD is positive now or by history, the following are required.

• Positive PPD: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_  
Month Day Year (Record mm of induration, transverse diameter)

• Chest X-ray (Please attach the report, not the X-ray)

Date performed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
Month Day Year

• Clinical Evaluation: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
DESCRIBE

• Treatment: No \_\_\_ Yes \_\_\_ Date treatment started \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year  
Drug \_\_\_\_\_  
Dose \_\_\_\_\_  
Frequency \_\_\_\_\_  
Date treatment completed \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Health Care Provider (Print) \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Health Care Provider Signature (Required) \_\_\_\_\_ MD/DO/NP/PA

**PART 3.**

**PHYSICAL EXAMINATION**

**MUST BE COMPLETED BY A HEALTH CARE PROVIDER**

*Required for Nursing Students, Athletic Training Students, and Athletes. Strongly recommended for other students.*

Name \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last First Middle Date of Birth

Date of Exam \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Allergies \_\_\_\_\_

The physical examination and laboratory tests must have been performed within the past year.

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

	System	Normal	Abnormal	Explanation of Abnormal Findings
1	Skin			
2	HEENT			
3	Chest, lungs			
4	Breasts			
5	Heart/Vascular			
6	Abdomen			
7	Hernia			
8	Genito-Urinary			
9	Pelvic (if indicated)			
10	Lymphatic			
11	Musculoskeletal			
12	Neurological			
13	Endocrine			
14	Psychological			

Recommended Lab Work: Hgb/Hct \_\_\_\_\_ Urine: Glucose \_\_\_\_\_ Protein \_\_\_\_\_ Micro \_\_\_\_\_

**Current and Chronic Health Problems**

*Please attach additional clinical reports to assist us in providing continuity of care.*

- 1. \_\_\_\_\_ 3. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_

**Current Medications**

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
- 2. \_\_\_\_\_ 5. \_\_\_\_\_
- 3. \_\_\_\_\_ 6. \_\_\_\_\_

Is this student fit to participate, without restrictions, in a collegiate athletic program? Yes \_\_\_\_\_ No \_\_\_\_\_

Health Care Provider (Print) \_\_\_\_\_

Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Health Care Provider Signature (Required) \_\_\_\_\_ MD/DO/NP/PA

**Mail completed form to:** Salem State University  
Counseling and Health Services  
352 Lafayette Street, Salem, Massachusetts 01970