

Ellison Campus Center, Suite 107
352 Lafayette Street
Salem, Massachusetts 01970

For Health Services Use Only

Allergies:
MMR #1____ #2____
Varicella #1____ Varicella #2____
Tetanus____ Tdap____
Hep B #1____ #2____ #3____
Meningococcal____
PPD____ POS____ CXR____ INH____
HIPAA____
Date Rec.____
Complete____ Computer____

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

Birth Place (country) _____

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 Work Phone Relationship to Student

2. _____
Name Home Phone Work 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)

Student/Parent/Guardian Signature

HEALTH INSURANCE INFORMATION

Insurance Carrier _____

Policy Number _____

Policy Holder's Name _____

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 a first year student? yes no

Health Science major? yes no

Attending with a student visa? 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: or Tdap in the last five years for full time freshmen or health science major

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 Year Month Year

OR

2. Meningococcal Vaccine Waiver Date /
(Waiver must be signed and attached to this form) Month Year

E. VARICELLA: Titer required for nursing students Two doses required for full-time freshmen or Health Science major

1. History of Varicella (Chicken Pox) Yes No

2. Varicella antibody titer Date / IGG Pos Neg
Month 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 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