

Counseling & Health Services

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

For Health Services Use Only

Allergies:
MMR #1 _____ #2 _____
Measles #1 _____ #2 _____
Mumps _____ Rubella _____
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 SSC Student ID Number

Date of Birth _____ / _____ / _____ Male _____ Female _____ Transgender _____
Month Day Year

Birth Place (country) _____

Date Entering SSC _____ / _____ Undergraduate _____ Graduate _____ Transfer _____ International _____ ESL _____
Month Year

Permanent Address _____
Street

City State Country Zip Code

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 COLLEGE

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

Table with 4 columns: Include Copy of Results, Date, Immune, Non Immune. Rows for Measles, Mumps, and Rubella.

B. TETANUS-DIPHTHERIA: Td or Tdap in the last ten years

1. Tetanus-Diphtheria (Td) or Tetanus-Diphtheria-Pertussis (Tdap) booster

TD Month/Day/Year OR Tdap Month/Day/Year

C. HEPATITIS B:

- 1. Vaccine Dose #1 Month/Day/Year Dose #2 Month/Day/Year Dose #3 Month/Day/Year

OR

- 2. Hepatitis B surface antibody Date Month/Day/Year Result: Reactive Non-reactive

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

- 1. Menactra Date Month/Year OR Menomune Date Month/Year

OR

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

E. VARICELLA: Titer required for nursing students

- 1. History of Varicella (Chicken Pox) Yes No
2. Varicella antibody titer Date Month/Year IGG Numerical Reading Pos Neg
3. Varicella vaccine (Must be given at least one month apart if immunized after age 13).

Dose #1 Month/Day/Year Dose #2 Month/Day/Year

F. TUBERCULOSIS SCREENING (PPD Skin Test)

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 College.

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 College
Counseling & Health Services
352 Lafayette Street, Salem, MA 01970