



WELLESLEY COLLEGE HEALTH SERVICE

FALL ADMISSION DUE DATE—JUNE 20
SPRING ADMISSION DUE DATE—JANUARY 13

Dear Incoming Student,

Welcome to Wellesley College! All of us at the Health Service look forward to meeting you and helping you attend to your health needs.

The Health Service plays an important role in supporting the overall well-being of each student. It is available at no cost to all students enrolled on campus, regardless of insurance. Our mission is to help you maintain your good health while you are here. To achieve that purpose, it is essential that you review and submit the Student Health History Forms and Health Care Provider Forms in their entirety by the required deadline: Fall Admission due date is June 20; Spring Admission due date is January 13.

The forms in this packet must be completed by you as the entering student, and by your examining physician. Please download all the pages of this document, and complete pages 1–3, *Student Health History and Medical Evaluation Form* and *Permission for Treatment*. The *Permission for Treatment* form must be completed and signed by your legal guardian if you will be younger than 18 when you enter Wellesley College.

Please bring pages 4–11 to your Health Care Provider's office for your Provider's review, completion and signature where indicated. These forms cannot be completed by a parent clinician.

You may use the Health Form Check List to keep track of the required forms and documents. Please note that failure to complete all health information, including required immunizations, will prevent you from registering for classes.

All students must ensure that the following completed and signed documents are returned to the Wellesley College Health Service:

- Student Health History and Medical Evaluation Form with photo attached
- Permission for Treatment, Authorization for Payment, and Consent for Treatment of Minors Form
- Physical Examination Form
- Immunization Record
- Tuberculosis Screening Questionnaire
- Tuberculosis Risk Assessment
- Waiver for Meningococcal Vaccination Requirement (optional)

If you have a disability, it is appropriate to complete a Disability Service Information Form via My Wellesley. Providing a full history, your current status, and any specific needs you have will be helpful in addressing your needs. You may be contacted directly by the Disability Services Office if additional information is needed.

Information regarding health insurance, mandatory in Massachusetts, will be forwarded to you separately. Please review it carefully before “waiving” or opting out of the student health insurance program, particularly if you anticipate participating in sports or if your home is more than 200 miles from the college campus.

We are happy that you are coming. The Health Service is well staffed with nurses, nurse practitioners, and board-certified physicians who are available to provide primary medical and gynecologic care. All medical information is strictly confidential and can only be released with your permission.

We'll see you soon!

Vanessa M. Britto, M.D., M.Sc.
Director, Health Service

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HEALTH FORM CHECK LIST

Before returning the enclosed documents, please make sure you have completed the following:

- Have you entered all information onto the Wellesley College form? Is the information in English?
- Completed and signed pages 1 and 2?
- Attached a photo?
- Had a physical exam since January 1?
- Did your physician complete and sign page 8?
- Did your physician give a recommendation for physical activity?
- Did you have the required blood work and urine test since January 1?
- Are the results provided on page 8?
- Did you provide the full dates (month/day/year) of your:
 - TWO** measles immunizations? (Massachusetts State Law requires 2 doses after your first birthday)
 - Most recent Tetanus (Td) or Tetanus/acellular/pertussis booster (Tdap)? (Must have been given within the last 10 years)
 - Three Hepatitis B immunizations? (Please obtain as many doses according to schedule as possible)
 - Meningococcal vaccine? (Please sign waiver if applicable)
 - Most recent Polio booster?
- Did you obtain all required lab tests and immunizations? If not, **please obtain** before sending form.
- Did your physician complete and sign page 9?
- Did you complete the TB Risk Assessment form?
 - If you have a history of past treatment for Latent TB Infection (positive PPD), please send copy of the most recent chest x-ray report and proof of treatment completed.

REMINDER: Incomplete forms will be returned to you and may result in delay upon your arrival to campus. Failure to provide **complete health information may result in blocked registration of your classes.**

FALL ADMISSION DUE DATE—JUNE 20
SPRING ADMISSION DUE DATE—JANUARY 13

STUDENT HEALTH HISTORY
AND MEDICAL EVALUATION FORM

TO THE STUDENT:

The information is strictly for the use of the Health and Counseling services and will not be released to anyone without your knowledge and consent.

PLEASE ATTACH
PHOTO HERE
WITH NAME ON BACK
(REQUIRED)

TO THE EXAMINING CLINICIAN:

1. The physical examination must have been performed **since January 1 of the entrance year.**
2. Please review page 4.
3. Complete and sign pages 5 and 9.
4. Complete and sign pages 7 and 8 when appropriate.

All forms must be complete before they are returned.

Full clearance for registration will not be granted until all preregistration medical requirements have been met.

(Please print clearly)

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	RELIGION
STREET ADDRESS		CITY	STATE	ZIP CODE
HOME TELEPHONE NO.				
E-MAIL ADDRESS				
NAME OF PARENT OR LEGAL GUARDIAN		ADDRESS	TELEPHONE NO.	
EMERGENCY CONTACT NAME		ADDRESS	TELEPHONE NO.	
PLACE OF BIRTH	CITIZENSHIP	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other MARITAL STATUS		
HEALTH INSURANCE COMPANY	POLICY NUMBER	STATE	SUBSCRIBER	

What are you allergic to? (Please list below)

MEDICATIONS (NAME):	REACTION:	FOOD (NAME):	REACTION:	OTHER (NAME):	REACTION:

Please list any major illnesses, operations, hospitalizations, or injuries that you have had throughout your life.

ILLNESS OR OPERATION	DATE	NAME OF HOSPITAL (IF APPLICABLE)	ADDRESS

Have you had:

	YES	NO		YES	NO		YES	NO
1. CHICKEN POX	<input type="checkbox"/>	<input type="checkbox"/>	18. SICKLE CELL TRAIT/DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	36. HEAD INJURY/CONCUSSION	<input type="checkbox"/>	<input type="checkbox"/>
2. SEASONAL ALLERGIES	<input type="checkbox"/>	<input type="checkbox"/>	19. ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	37. DIZZINESS/FAINTING	<input type="checkbox"/>	<input type="checkbox"/>
3. ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	20. BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	38. SEIZURE, EPILEPSY	<input type="checkbox"/>	<input type="checkbox"/>
4. TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	21. LEUKEMIA, LYMPHOMA, CANCER	<input type="checkbox"/>	<input type="checkbox"/>	39. ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)	<input type="checkbox"/>	<input type="checkbox"/>
5. BRONCHITIS/PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	22. TUMOR, CYST	<input type="checkbox"/>	<input type="checkbox"/>	40. INSOMNIA	<input type="checkbox"/>	<input type="checkbox"/>
6. SINUSITIS	<input type="checkbox"/>	<input type="checkbox"/>	23. JAUNDICE, HEPATITIS	<input type="checkbox"/>	<input type="checkbox"/>	41. FREQUENT ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>
7. LOSS OF HEARING	<input type="checkbox"/>	<input type="checkbox"/>	24. STOMACH PROBLEM, ULCER	<input type="checkbox"/>	<input type="checkbox"/>	42. FREQUENT DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
8. EYE PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	25. INTESTINAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	43. SUICIDAL THOUGHTS OR ATTEMPTS	<input type="checkbox"/>	<input type="checkbox"/>
9. DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	26. URINARY TRACT INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	44. PREOCCUPATION WITH WEIGHT AND FOOD	<input type="checkbox"/>	<input type="checkbox"/>
10. THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	27. KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	45. USE OF LAXATIVES OR VOMITING FOR WEIGHT CONTROL	<input type="checkbox"/>	<input type="checkbox"/>
11. PALPITATIONS	<input type="checkbox"/>	<input type="checkbox"/>	28. ABNORMAL PAP	<input type="checkbox"/>	<input type="checkbox"/>	46. RECURRENT WEIGHT LOSS/GAIN	<input type="checkbox"/>	<input type="checkbox"/>
12. HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	29. SEXUALLY TRANSMITTED INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	47. ANOREXIA/BULIMIA	<input type="checkbox"/>	<input type="checkbox"/>
13. HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	30. MALARIA	<input type="checkbox"/>	<input type="checkbox"/>	48. COUNSELING OR PSYCHOTHERAPY	<input type="checkbox"/>	<input type="checkbox"/>
14. HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	31. MONONUCLEOSIS	<input type="checkbox"/>	<input type="checkbox"/>	49. HOSPITALIZATION FOR A PHYSICAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
15. DISEASE/INJURY OF JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	32. SEVERE ACNE	<input type="checkbox"/>	<input type="checkbox"/>	50. HOSPITALIZATION FOR A PSYCHIATRIC PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>
16. BACK PROBLEMS/SCOLIOSIS	<input type="checkbox"/>	<input type="checkbox"/>	33. ECZEMA. PSORIASIS	<input type="checkbox"/>	<input type="checkbox"/>	51. ANY OTHER PROBLEMS NOT LISTED	<input type="checkbox"/>	<input type="checkbox"/>
17. ABSENCE/LOSS OF PAIRED ORGAN (EYE/KIDNEY, ETC.)	<input type="checkbox"/>	<input type="checkbox"/>	34. BODY PIERCING/TATTOOS	<input type="checkbox"/>	<input type="checkbox"/>			
			35. RECURRENT HEADACHE	<input type="checkbox"/>	<input type="checkbox"/>			

Please give details for each "yes." (Use a separate sheet if needed.)

Currently prescribed medications (with dosage and frequency)

Substance abuse:

	NEVER	PAST	CURRENT	AMOUNT
CIGARETTES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
MARIJUANA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
COCAINE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Habits:

	FREQUENTLY	SOME	NEVER
EXERCISE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SEAT BELTS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BIKE HELMET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Family history:

	AGE	STATE OF HEALTH	OCCUPATION	AGE AT DEATH	CAUSE OF DEATH
FATHER					
MOTHER					
BROTHER					
SISTER					
SON					
DAUGHTER					

Have any of your immediate relatives had any of the following?

	YES	NO	RELATIONSHIP
ANOREXIA OR BULIMIA	<input type="checkbox"/>	<input type="checkbox"/>	_____
ASTHMA, HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	_____
CANCER	<input type="checkbox"/>	<input type="checkbox"/>	_____
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	_____
THYROID PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	_____
EPILEPSY, CONVULSION	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART ATTACK BEFORE AGE 60	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	_____
HIGH CHOLESTEROL	<input type="checkbox"/>	<input type="checkbox"/>	_____
KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	_____
STOMACH/INTESTINAL PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	_____
EMOTIONAL PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	_____
ALCOHOLISM	<input type="checkbox"/>	<input type="checkbox"/>	_____
MANIC DEPRESSIVE DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	_____
SCHIZOPHRENIA	<input type="checkbox"/>	<input type="checkbox"/>	_____

STUDENT'S SIGNATURE _____

DATE _____

CLINICIAN'S SIGNATURE (M.D., N.P., PA) _____
(Indicating review) (not parent clinician)

DATE _____



PERMISSION FOR TREATMENT

I understand that the information that I have given in the pre-entrance health history is confidential and is only for the use of the Wellesley College Health and Counseling Services. I hereby authorize the Wellesley College Health Service to provide diagnostic and therapeutic treatment, including voluntary immunization, as deemed necessary by the medical staff. I understand that this health information may be shared with treatment providers only to coordinate and manage my health care, and/or to comply with state/federal laws.

AUTHORIZATION OF PAYMENT

I hereby authorize Wellesley College Health Service to bill me for services that are not covered by my health insurance plan. On my behalf, the Wellesley College Health Service may release information to my insurer, upon request, to facilitate payment of health insurance claims.

The signature below acknowledges understanding of these statements regarding permission for treatment and authorization of payment

STUDENT'S SIGNATURE _____ DATE _____

STUDENT'S PRINTED NAME _____ DATE _____

CONSENT FOR TREATMENT OF MINORS (for students under 18 years)

This consent form must be signed by the parent or legal guardian of minors (under 18 years) such that appropriate diagnostic and therapeutic treatment may be promptly carried out.

The signature below acknowledges understanding of the above statements regarding treatment and authorization of payment. (I understand that in emergency situations, effort will be made to contact the parent/guardian, prior to treatment.)

STUDENT'S NAME _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PARENT/GUARDIAN PRINTED NAME _____ DATE _____



Dear Health Care Provider:

We are excited to have your patient as an incoming student at Wellesley College! The Wellesley College Health Service is well staffed with board-certified physicians, nurses, nurse practitioners, a nutritionist, and physical therapist. We are available to assist you in providing or continuing primary medical and gynecologic care.

To assist us in complying with Massachusetts law and in preparing to care for your patient please provide us with the following:

- Please complete the attached physical examination and required immunization forms.
- Please complete and sign page 5 (physical examination and physical education limits)
- Please review the TB Questionnaire with the student (page 6); if yes to any screening questions please complete the TB Risk Assessment (page 7-8)
- Please review, complete and sign page 9 (required* and recommended** immunizations)

***Required immunizations must be administered and documented before enrollment:**

- Hepatitis B—completed series
- Tetanus—Tdap/Td booster within past 10 years
- Measles, Mumps, Rubella (MMR)—2 doses
- Meningitis (Menactra or Menomune)—or completion of authorized waiver (page 11)

****Recommended immunizations:**

- Polio—4 doses (including booster) after 4th birthday
- Varicella—2 doses if no reliable history or available titre
- HPV Vaccine—3 doses (series can be completed at Wellesley)

The student will be responsible for returning your completed and signed forms to the Wellesley College Health Service by June 20.

Note: Massachusetts state law allows the following exemptions to the immunization requirements:

Religious exemption: Statements must be accompanied by an official letter from clergy of the practicing faith stating that obtaining immunizations is in opposition to the student's religious faith. The statement must include the duration of time that the student has been practicing.

Medical exemption: Statements must be accompanied by an official letter from the student's medical doctor (MD), nurse practitioner (NP), or physician's assistant (PA) stating the medical reason for the exemption.

Philosophical exemptions are NOT recognized by Massachusetts law and therefore cannot be accepted by Wellesley College.

If you have additional medical information that you believe would be helpful to us as we care for your patient while she is here, please feel free to include that information on the physical examination form or you may forward it separately. For your convenience, our fax number is 781.283.3693.

Sincerely,

Vanessa M. Britto, M.D., M.Sc.
Director, Health Service

PHYSICAL EXAMINATION

STUDENT'S NAME: _____

DATE OF EXAMINATION: _____

(Must be since January 1. Cannot be completed by parent clinician.)

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

Laboratory tests:

HEMOGLOBIN OR HEMATOCRIT (REQUIRED) _____

URINALYSIS (REQUIRED) SUGAR: _____ PROTEIN: _____

CHOLESTEROL _____

OTHER _____

Vision:

RIGHT LEFT

UNCORRECTED 20/ _____ 20/ _____

CORRECTED 20/ _____ 20/ _____

CONTACT LENS YES NO

PRESCRIPTION: _____

	NORMAL	ABNORMAL	DESCRIBE ABNORMALITIES
SKIN, LYMPH NODES	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEAD, NOSE, SINUSES	<input type="checkbox"/>	<input type="checkbox"/>	_____
MOUTH, TEETH, GINGIVA	<input type="checkbox"/>	<input type="checkbox"/>	_____
EARS (CANALS, DRUMS)	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEARING	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES (SEE ABOVE)	<input type="checkbox"/>	<input type="checkbox"/>	_____
THROAT, THYROID	<input type="checkbox"/>	<input type="checkbox"/>	_____
LUNGS, CHEST	<input type="checkbox"/>	<input type="checkbox"/>	_____
HEART	<input type="checkbox"/>	<input type="checkbox"/>	_____
BREASTS	<input type="checkbox"/>	<input type="checkbox"/>	_____
BACK	<input type="checkbox"/>	<input type="checkbox"/>	_____
ABDOMEN	<input type="checkbox"/>	<input type="checkbox"/>	_____
PELVIC (IF INDICATED)	<input type="checkbox"/>	<input type="checkbox"/>	_____
EXTREMITIES, JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	_____
NEURO	<input type="checkbox"/>	<input type="checkbox"/>	_____

PLEASE CHECK IF THE STUDENT INTENDS TO PARTICIPATE IN INTERCOLLEGIATE ATHLETICS. PLEASE INDICATE TEAM _____

RECOMMENDATION FOR PHYSICAL EDUCATION:

UNLIMITED LIMITED EXPLAIN: _____

Please describe any significant illnesses, injuries, or hospitalizations in this patient's past history.

Please comment on any physical or emotional problems that the health service should be aware of regarding this patient, including past history, medications, and current treatments.

CLINICIAN'S NAME (not parent clinician)

CLINICIAN'S SIGNATURE (M.D., N.P., PA)

DATE

ADDRESS

TELEPHONE NO.

FAX NO.

TUBERCULOSIS SCREENING QUESTIONNAIRE

STUDENT'S NAME: _____

For completion by: ALL STUDENTS

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Have you ever had a positive TB skin test? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever had close contact with anyone who was sick with TB? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Were you born in one of the countries listed below and arrived in the U.S. within the past 5 years? * (If yes, please CIRCLE the country) | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever traveled** to/in one or more of the countries listed below? (If yes, please CIRCLE the country/ies) | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever been vaccinated with BCG? | <input type="checkbox"/> | <input type="checkbox"/> |

* future CDC updates may eliminate the 5 year time frame

** The significance of the travel exposure should be discussed with a health care provider and evaluated.

AFGHANISTAN	COMOROS	IRAN	MOZAMBIQUE	SEYCHELLES
ALGERIA	CONGO	IRAQ	MYANMAR	SIERRA LEONE
ANGOLA	CONGO, DR	JAMAICA	NAMIBIA	SINGAPORE
ARGENTINA	COTE D'IVOIRE	JAPAN	NEPAL	SOLOMON ISLANDS
ARMENIA	CROATIA	KAZAKHSTAN	NEW CALEDONIA	SOMALIA
AZERBAIJAN	CZECH REPUBLIC	KENYA	NICARAGUA	SOUTH AFRICA
BANGLADESH	DJIBOUTI	KIRIBATI	NIGER	SRI LANKA
BELARUS	DOMINICAN REP.	KOREA, DPR	NIGERIA	SUDAN
BELIZE	ECUADOR	KOREA, REP.	NIUE	SURINAME
BENIN	EL SALVADOR	KYRGYZSTAN	NORTHERN MARIANA ISLANDS	SWAZILAND
BHUTAN	ENGLAND	LAO PDR	PAKISTAN	SYRIAN ARAB REP.
BOLIVIA	EQUATORIAL GUINEA	LATVIA	PALAU	TAIWAN
BOSNIA & HERZEGOVINA	ERITREA	LESOTHO	PANAMA	TAJIKISTAN
BOTSWANA	ESTONIA	LIBERIA	PAPUA NEW GUINEA	THAILAND
BRAZIL	ETHIOPIA	LITHUANIA	PARAGUAY	TOGO
BRUNEI DARUSSALAM	GABON	MACEDONIA, TFYR	PERU	TURKMENISTAN
BULGARIA	GAMBIA	MADAGASCAR	PHILIPPINES	TUVALU
BURKINA FASO	GEORGIA	MALAWI	POLAND	UGANDA
BURUNDI	GHANA	MALAYSIA	PORTUGAL	UKRAINE
CAMBODIA	GUAM	MALDIVES	QATAR	UNITED REPUBLIC OF TANZANIA
CAMEROON	GUATEMALA	MALI	ROMANIA	UZBEKISTAN
CAPE VERDE	GUINEA	MARSHALL ISLANDS	RUSSIAN FEDERATION	VANUATU
CENTRAL AFRICA REP.	GUINEA-BISSAU	MAURITANIA	REPUBLIC OF MOLDOVA	VIETNAM
CHAD	GUYANA	MAURITIUS	RWANDA	WALLIS & FUTUNA
CHINA	HAITI	MEXICO	SAO TOME & PRINCIPE	YEMEN
CHINA, HONG KONG SAR	HONDURAS	MICRONESIA	SAUDI ARABIA	ZAMBIA
CHINA, MACAU SAR	INDIA	MONGOLIA	SENEGAL	
COLOMBIA	INDONESIA	MOROCCO		

If the answer is YES to any of the above questions, Wellesley College requires that a health care provider complete a tuberculosis risk assessment (to be completed within 6 months prior to the start of classes).

If the answer to all of the above questions is NO, no further testing or further action is required.

TUBERCULOSIS RISK ASSESSMENT

STUDENT'S NAME: _____

Wellesley College Health Service

Persons with any of the following are candidates for either Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA), unless a previous positive test has been documented:

	YES	NO
1. Recent close contact with someone with infectious TB disease	<input type="checkbox"/>	<input type="checkbox"/>
2. Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	<input type="checkbox"/>	<input type="checkbox"/>
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	<input type="checkbox"/>	<input type="checkbox"/>
4. HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
5. Organ transplant recipient	<input type="checkbox"/>	<input type="checkbox"/>
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-antagonist)	<input type="checkbox"/>	<input type="checkbox"/>
7. History of illicit drug use	<input type="checkbox"/>	<input type="checkbox"/>
8. Resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)	<input type="checkbox"/>	<input type="checkbox"/>
9. Medical condition associated with increased risk of progressing to TB disease if infected [e.g., diabetes mellitus, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal for the given population)]	<input type="checkbox"/>	<input type="checkbox"/>
* The significance of the travel exposure should be discussed with a health care provider and evaluated.		
10. Does the student have signs or symptoms of active tuberculosis disease? If No, proceed to 12 or 13. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.	<input type="checkbox"/>	<input type="checkbox"/>

TUBERCULOSIS RISK ASSESSMENT

Wellesley College Health Service

STUDENT'S NAME: _____

11. Tuberculin Skin Test (TST)

(TST result should be recorded as actual millimeters (mm) of induration, transverse diameter; if noinduration, write "0". The TST interpretation should be based on mm of induration as well as risk factors.)**

Date Given: ___/___/___
 M D Y

Date Read: ___/___/___
 M D Y

Result: _____ mm of induration **Interpretation: positive___ negative___

Date Given: ___/___/___
 M D Y

Date Read: ___/___/___
 M D Y

Result: _____ mm of induration **Interpretation: positive___ negative___

12. Interferon Gamma Release Assay (IGRA)

Date Obtained: ___/___/___ (specify method) QFT-G QFT-GIT other___
 M D Y

Result: Negative___ Positive___ Intermediate___

Date Obtained: ___/___/___ (specify method) QFT-G QFT-GIT other___
 M D Y

Result: Negative___ Positive___ Intermediate___

13. Chest x-ray: (Required if TST or IGRA is positive)

Date of chest x-ray: ___/___/___ Result: normal___ abnormal___
 M D Y

**Interpretation guidelines

>5 mm is positive:

- Recent close contacts of an individual with infectious TB
- Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- Organ transplant recipients
- Immunosuppressed persons: taking > 15 mg/d of prednisone for > 1 month; taking a TNF- antagonist
- Persons with HIV/AIDS

>10 mm is positive:

- Persons born in a high prevalence country or who resided in one for a significant* amount of time
- History of illicit drug use
- Mycobacteriology laboratory personnel
- History of resident, worker or volunteer in high-risk congregate settings
- Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes

>15 mm is positive:

- Persons with no known risk factors for TB disease

Clinician's Signature

Date

Clinician's Printed Name

IMMUNIZATION RECORD This part must be completed and signed by a clinician (M.D., N.P., and P.A.) Must include month, day, and year..

VACCINE	DATE 1	DATE 2	DATE 3	DATE 4	DATE 5
REQUIRED BY MA LAW:					
MMR ^(1,2) OR					
MEASLES					
MUMPS					
RUBELLA					
DPT					
HEP B ⁽²⁾					
MENINGOCOCCAL		Menactra <input type="checkbox"/>	Menomune <input type="checkbox"/>		
TETANUS BOOSTER ⁽³⁾		Tdap <input type="checkbox"/>	Td <input type="checkbox"/>		
RECOMMENDED:					
POLIO					
VARICELLA (CHICKEN POX)					
HUMAN PAPILOMA VIRUS (HPV)					
HEP A					
OTHER:					

¹ Two immunizations administered after 1/1/68, after first birthday and at least one month apart.

² Please follow recommended dosing schedule, if not, we will request titre. Note: Titre may be used for Measles, Mumps, Rubella, HepB, Chicken Pox. Lab report must be sent.

³ Tetanus Booster must be within the last 10 years.

VACCINE EXEMPTIONS

Massachusetts state law allows the following exemptions to the immunization requirements:

Religious exemption: Statements must be accompanied by an official letter from the pastor, rabbi, or minister of the practicing faith stating that it is against the student's religious beliefs to receive any immunizations. The letter must also state how long the student has been a member of that faith.

Medical exemption: An official letter from a medical doctor (MD), nurse practitioner (NP), or physician's assistant (PA) stating the medical reason for exemption.

Philosophical exemptions are **not permitted** by Massachusetts state law and will not be accepted by Wellesley College.

CLINICIAN'S SIGNATURE (M.D., N.P., PA) (not parent clinician) **DATE**

*PLEASE PRINT NAME & ADDRESS IF DIFFERENT FROM PAGE 3.

DO NOT WRITE BELOW THIS LINE

WELLESLEY COLLEGE HEALTH SERVICE

DATE GIVEN	VACCINE	DOSE AND ROUTE OF ADMINISTRATION	MANUFACTURER'S NAME	VACCINE LOT NUMBER	SIGNATURE OF PERSON ADMINISTERING VACCINE

PPDS: DATE GIVEN: _____ DOSE: _____ MFG/LOT # _____ DATE READ: _____ RESULT: _____ mm SIG: _____
 DATE GIVEN: _____ DOSE: _____ MFG/LOT # _____ DATE READ: _____ RESULT: _____ mm SIG: _____

REVIEWED BY: _____ **DATE:** _____

Complete
 Incomplete
 History
 Td
 Measles
 Lab
 Referred to MD
 Physical
 Polio
 Rubella
 TB Assessment
 MD Review
 Hep B
 Meningitis
 Mumps
 Photo
 HS letter
 Waiver
 Joint letter



Information about Meningococcal Disease and Vaccination and Waiver for Students at Residential Schools and Colleges

Revised legislation in Massachusetts now requires all newly enrolled full-time students attending a secondary school (e.g., boarding schools) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to:

1. receive meningococcal vaccine; or
2. fall within one of the exemptions in the law, which are discussed on the reverse side of this sheet.

The law provides an exemption for students signing a waiver that reviews the dangers of meningococcal disease and indicates that the vaccination has been declined. To qualify for this exemption, you are required to review the information below and sign the waiver at the end of this document. Please note, if a student is under 18 years of age, a parent or legal guardian must be given a copy of this document and must sign the waiver.

What is meningococcal disease?

Meningococcal disease is caused by infection with bacteria called *Neisseria meningitidis*. These bacteria can infect the tissue that surrounds the brain and spinal cord called the “meninges” and cause meningitis, or they can infect the blood or other body organs. In the US, about 1,000-3,000 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 11-19% lose their arms or legs, become deaf, have problems with their nervous systems, become mentally retarded, or suffer seizures or strokes.

How is meningococcal disease spread?

These bacteria are passed from person-to-person through saliva (spit). You must be in close contact with an infected person’s saliva in order for the bacteria to spread. Close contact includes activities such as kissing, sharing water bottles, sharing eating/drinking utensils or sharing cigarettes with someone who is infected; or being within 3-6 feet of someone who is infected and is coughing or sneezing.

Who is at most risk for getting meningococcal disease?

People who travel to certain parts of the world where the disease is very common are at risk, as are military recruits who live in close quarters. Children and adults with damaged or removed spleens or an inherited disorder called “terminal complement component deficiency” are at higher risk. People who live in settings such as college dormitories are also at greater risk of infection.

Are some students in college and secondary schools at risk for meningococcal disease?

College freshmen living in residence halls or dormitories are at an increased risk for meningococcal disease as compared to individuals of the same age not attending college. The setting, combined with risk behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and activities involving the exchange of saliva), may be what puts college students at a greater risk for infection. There is insufficient information about whether new students in other congregate living situations (e.g., residential schools) may also be at increased risk for meningococcal disease. But, the similarity in their environments and some behaviors may increase their risk.

The risk of meningococcal disease for other college students, in particular older students and students who do not live in congregate housing, is not increased. However, meningococcal vaccine is a safe and efficacious way to reduce their risk of contracting this disease.

Is there a vaccine against meningococcal disease?

Yes, there are currently 2 vaccines available that protect against 4 of the most common of the 13 serogroups (subgroups) of *N. meningitidis* that cause serious disease. Meningococcal polysaccharide vaccine is approved for use in those 2 years of age and older and meningococcal conjugate vaccine is approved for use in those 2-55 years of age. Both of the vaccines provide protection against four serogroups of the bacteria, called groups A, C, Y and W-135. These four serogroups account for approximately two-thirds of the cases that occur in the U.S. each year. Most of the remaining one-third of the cases are caused by serogroup B, which is not contained in either vaccine. Protection with the meningococcal polysaccharide vaccine is not lifelong; it lasts about 3 to 5 years in healthy adults (some people may be protected longer.) The meningococcal conjugate vaccine is expected to help decrease disease transmission and provide more long-term protection.

(See reverse side)

Is the meningococcal vaccine safe?

A vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions. Getting meningococcal vaccine is much safer than getting the disease. Some people who get meningococcal vaccine have mild side effects, such as redness or pain where the shot was given. These symptoms usually last for 1-2 days. A small percentage of people who receive the vaccine develop a fever. The vaccine can be given to pregnant women.

A few cases of Guillain-Barré syndrome (GBS), a rare but serious nervous system disorder, have been reported among people who received meningococcal conjugate vaccine. This information is still being evaluated by health officials. An ongoing risk of serious meningococcal disease exists. At this time, experts continue to recommend vaccination for those at increased risk of acquiring meningococcal disease. However, persons who have had GBS should generally not receive meningococcal conjugate vaccine, and should talk to their doctor about their other options for vaccination.

Is it mandatory for students to receive meningococcal vaccine for entry into secondary schools or colleges that provide or license housing?

Massachusetts law (MGL Ch. 76, s.15D) requires newly enrolled full-time students attending a secondary school (those schools with grades 9-12) or postsecondary institution (e.g., colleges) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution to receive meningococcal vaccine. At affected secondary schools, the requirements apply to all new full-time residential students, regardless of grade (including grades pre-K through 8) and year of study. All students covered by the regulations must provide documentation of having received a dose of meningococcal polysaccharide vaccine within the last 5 years (or a dose of meningococcal conjugate vaccine at any time in the past), unless they qualify for one of the exemptions allowed by the law. Whenever possible, immunizations should be obtained prior to enrollment or registration. However, students may be enrolled or registered provided that the required immunizations are obtained within 30 days of registration.

Students may begin classes without a certificate of immunization against meningococcal disease if: 1) the student has a letter from a physician stating that there is a medical reason why he/she can't receive the vaccine; 2) the student (or the student's parent or legal guardian, if the student is a minor) presents a statement in writing that such vaccination is against his/her sincere religious belief; or 3) the student (or the student's parent or legal guardian, if the student is a minor) signs the waiver below stating that the student has received information about the dangers of meningococcal disease, reviewed the information provided elected to decline the vaccine.

Where can a student get vaccinated?

Students and their parents should contact their healthcare provider and make an appointment to discuss meningococcal disease, the benefits and risks of vaccination, and the availability of this vaccine. Schools and college health services are not required to provide you with this vaccine.

Where can I get more information?

- Your healthcare provider
- The Massachusetts Department of Public Health, Division of Epidemiology and Immunization at (617) 983-6800 or www.mass.gov/dph/imm and <http://www.mass.gov/epi>
- Your local health department (listed in the phone book under government)

Waiver for Meningococcal Vaccination Requirement

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools, colleges and universities who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school or postsecondary institution to receive meningococcal vaccinations, unless the students provide a signed waiver of the vaccination or otherwise qualify for one of the exemptions specified in the law.

- After reviewing the materials above on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name: _____ Date of Birth: _____

Student ID or SSN: _____

Signature: _____ Date: _____
(Student or parent/legal guardian, if student is under 18 years of age)