



Bridgewater State University Health and Wellness Form

Instructions: All full-time undergraduate and graduate students and any student with a student visa are required to submit a completed Health and Wellness form to the Wellness Center in Weygand Hall. The Health and Wellness form is required per Bridgewater State University policy and is in accordance with the Massachusetts College Immunization Law. Physicals are strongly recommended for all students but are not required. Forms can be faxed or mailed to: *BSU Wellness Center ♦ Weygand Hall ♦ 351 Great Hill Drive ♦ Bridgewater, MA 02325 ♦ Fax:508-531-6193* **Registration for classes will be affected if this information is not completed.** For questions call: 508-531-1252

Part 1: Demographic Information

Name: _____ Banner ID #: _____
Last First MI
 Date of Birth: _____ / _____ / _____ Country of Birth: _____
Month Day Year
 Permanent Address: _____
Street City State Zip Country
 On Campus Address: _____
Residence Hall Rm # or off campus address
 Phone number (cell) _____ (home) _____
 Emergency Contact: _____
Name Cell phone Relation
 Health Insurance Name: _____ Health Insurance ID #: _____

Part 2: Consent for Medical Treatment for students under age 18

Signature of Parent/Guardian required if student is under 18 years of age

I, _____ hereby grant the Wellness Center at BSU permission to provide medical care to my son/daughter while he/she is a student at BSU, including examinations, immunizations, or other services, as necessary.

Name of Parent/Guardian: _____ Signature: _____ Date: _____

Part 3: Meningitis Waiver: *Students who have received the MenACWY vaccine can skip this section.*

Students may decline the MenACWY vaccine but first must review the MDPH Meningococcal Information sheet which can be found at <https://www.mass.gov/lists/meningitis-vaccination-requirements> or on the BSU Health Services website.

Waiver for Meningococcal Vaccination Requirement

I have reviewed the information on the risks of meningococcal disease and the risks and benefits of quadrivalent meningococcal conjugate vaccine. I understand that Massachusetts' law requires newly enrolled full-time students at secondary schools who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school, and newly enrolled full-time students at colleges and universities who are 21 years of age or younger 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 on the DPH website on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Student Name: _____ Date of Birth: _____ Student ID: _____
 Signature: _____ Date: _____

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Jan 2021



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Required Immunizations for Bridgewater State University (to be completed by Health Care Provider)

Name: _____ DOB: _____ Banner ID #: _____

All full-time students under the age of 30 and all international students (including those here on academic visitation) are required to submit the following immunizations or proof of immunity for admission. Please have your health care provider complete and sign this form or attach immunization documents from your provider, school, or military sources.

Check here if you are **over age 30 and not** an international student

<p>Tdap Vaccine 1 dose given at age 7-12</p> <p>____/____/____ month day year</p> <p>Td or Tdap: if over 10 years since last Tdap</p> <p>____/____/____ month day year</p>	<p>MMR #1 (on or after 1st birthday)</p> <p>____/____/____ month day year</p> <p>MMR #2 (given ≥ 28 days after dose 1)</p> <p>____/____/____ month day year</p>	<p>Hepatitis B #1</p> <p>____/____/____ month day year</p> <p>Hepatitis B #2</p> <p>____/____/____ month day year</p> <p>Hepatitis B #3</p> <p>____/____/____ month day year</p>
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Varicella (Chicken Pox)		
<p>Medical Proof of Disease</p> <p>____/____ month year</p>	<p>or</p> <p>Dose #1</p> <p>____/____/____ month day year</p>	<p>Dose # 2 (≥ 4 weeks dose 1)</p> <p>____/____/____ month day year</p>

Meningococcal Vaccine (MenACWY)*	
All newly enrolled FT students ≤ 21 years given on or after the students 16 th birthday	
____/____/____ month day year	
*Students may decline the MenACWY vaccine. Students must read the MDPH Meningococcal Information and sign the Waiver for Meningococcal Vaccination Requirement found on page 1.	

Tuberculosis Test	<input type="checkbox"/> Check here if student low risk for TB
TST: Date Given: ____/____/____	Date Read: ____/____/____
M D Y	M D Y
Result: ____ mm	<input type="checkbox"/> Positive <input type="checkbox"/> Negative
If positive: Chest x-ray ____/____/____	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No
M D Y	
IGRA (Interferon Gamma Release Assay)	
Date of IGRA blood Test: ____/____/____	Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No

Health Care Provider Information (Please complete.)

Health Care Provider Name (Please print.) _____ Office Address _____

Health Care Provider Signature _____ Date _____ Phone _____

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Tuberculosis Screening Form *(To be filled out and signed by student.)*

Name: _____ DOB: _____ Banner ID #: _____

Please answer the following questions and follow the instructions given after each section.

- | | | |
|--|-----------------------------|------------------------------|
| 1. Have you ever had close contact with person(s) known to have active TB disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 2. Were you born in one of the countries or territories listed below with a high prevalence of TB disease? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 3. Have you had frequent or prolonged visits to one or more countries or territories listed below? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 4. Have you ever lived or worked in a potentially high risk setting such as a prison, homeless shelter, drug treatment center, or long-term care facility? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| 5. Do you or anyone in your household have a history of HIV/AIDS or intravenous drug use? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Afghanistan	Burundi	El Salvador	Indonesia	Republic of Moldova	Tanzania (United Republic of)
Albania	Cabo Verde	Equatorial Guinea	Iraq	Romania	Thailand
Algeria	Cambodia	Eritrea	Kazakhstan	Russian Federation	Timor-Leste
Angola	Cameroon	Eswatini (formerly Swaziland)	Kenya	Rwanda	Togo
Anguilla	Central African Republic	Ethiopia	Kiribati	Sao Tome and Principe	Tunisia
Argentina	Chad	Fiji	Kuwait	Senegal	Turkmenistan
Armenia	China	French Polynesia	Kyrgyzstan	Sierra Leone	Tuvalu
Azerbaijan	China, Hong Kong	Gabon	Lao People's Democratic Republic	Singapore	Uganda
Bahamas	China, Macao SAR	Gambia	Niue	Solomon Islands	Ukraine
Bangladesh	Colombia	Georgia	Northern Mariana Is.	Somalia	Uruguay
Belarus	Comoros	Ghana	Pakistan	South Africa	Uzbekistan
Belize	Congo	Greenland	Palau	South Sudan	Vanuatu
Benin	Côte d'Ivoire	Guam	Panama	Sri Lanka	Venezuela (Bolivarian Republic of)
Bhutan	Democratic Republic of Congo	Guatemala	Papua New Guinea	Sudan	Viet Nam
Bolivia	Democratic Republic of Congo	Guinea	Paraguay	Suriname	Yemen
Bosnia and Herzegovina	Djibouti	Guinea-Bissau	Peru	Swaziland	Zambia
Botswana	Dominican Republic	Guyana	Philippines	Tajikistan	Zimbabwe
Brazil	Ecuador	Haiti	Portugal		
Brunei Darussalam		Honduras	Qatar		
Burkina Faso		India	Republic of Korea		

Have you ever had a positive TB test? No Yes

If **yes**, you must provide documentation of a negative chest x-ray done on or after the date of your positive TB test and any treatment that you may have received. **Please include documentation with this form.**

If you are **unable** to obtain chest x-ray or treatment results, please schedule an appointment with your Primary Care or call 508-531-1252 to schedule an appointment with BSU Wellness Center for consultation.

If you answered **no** to questions 1-5, no further action is required.

If you answered **yes** to any of the above 5 questions, BSU requires that you receive TB testing as soon as possible but at least prior to the start of your first semester. **Please include documentation with this form.**

If you have ever had a TB test, PPD, or Quantiferon TB test, you may submit a copy of your most recent TB test. BSU Wellness Staff will review documentation and the student will be contacted if additional TB testing is needed.

Students unable to have testing done by their PCP can have TB testing performed at the Wellness Center. Please call 508-531-1252 to schedule an appointment.

Student Signature: _____ Date: _____

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