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: ________________

FOR BSU WELLNESS CENTER OFFICE USE ONLY:

Jan 2020

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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 ❑

Tdap Vaccine 1 dose given at age 7-12 _____/_____/_____ month day year Td or Tdap: if over 10 years since last Tdap _____/_____/_____ month day year	**MMR #1 (on or after 1st birthday)** _____/_____/______ month day year MMR #2 (given ≥ 28 days after dose 1) _____/_____/_____ month day year	**Hepatitis B #1** _____/_____/_____ month day year Hepatitis B #2 _____/_____/_____ month day year Hepatitis B #3 _____/_____/_____ month day year

Varicella (Chicken Pox)

Medical Proof of Disease		Dose #1	Dose # 2 (≥ 4 weeks dose 1)
_______/_____ month year	or	_____/_____/_____ month day year	_____/_____/_____ month day year

Seasonal Influenza Vaccine: _____/_____/_____
month day year

Meningococcal Vaccine (MenACWY)*

All newly enrolled FT students ≤ 21 years given on or after the students 16th 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 ❑ Check here if student low risk for TB

TST: Date Given: ___/___ /___ Date Read: ___/___/___ Result: _____mm ❑ Positive ❑ Negative
M D Y M D Y

If positive: Chest x-ray ___/___/___ Result ❑ Positive ❑ Negative Treated: ❑ Yes ❑ No
M D Y

IGRA (Interferon Gamma Release Assay)

Date of IGRA blood Test: ___/___/___ Result ❑ Positive ❑ Negative Treated: ❑ Yes ❑ No

Health Care Provider Information (Please complete.)

________________________________ ____
Health Care Provider Name (Please print.) Office Address

________________________________ ______________________________ ______________________________
Health Care Provider Signature Date Phone

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

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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? ❑ No ❑ Yes
2. Were you born in one of the countries or territories listed below with a high prevalence of TB disease? ❑ No ❑ Yes
3. Have you had frequent or prolonged visits to one or more countries or territories listed below? ❑ No ❑ 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? ❑ No ❑ Yes
5. Do you or anyone in your household have a history of HIV/AIDS or intravenous drug use? ❑ No ❑ Yes

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

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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