Salem State University

Health Form 2019-2020 Academic Year
Student Information

Name of Student

Date of Birth

Student ID #

DEADLINE

to return completed form:

January 5 for students admitted for Spring 2019

August 5 for students admitted for Fall 2019

Check List

- ☐ Student Information (pg 1)
- ☐ Medical History (pg 2)
- ☐ Immunization Record (pg 3)
- ☐ TB Risk Questionnaire (pg 4 and 5)
- ☐ Student Health Insurance Information (pg 6)
- ☐ Keep "Health Care Options for Students" for your reference
- ☐ Copy of insurance cards attached (both sides)
- ☐ Keep a copy of this form for your records

Salem State University
Counseling and
Health Services
352 Lafayette Street
Salem, MA 01970

Phone: 978.542.6413

Fax: 978.542.7121

INSTRUCTIONS

All full-time undergraduate and graduate students, any student with a student visa and all health science majors are required to return the completed health report to health services no later than the deadline. This Health and Immunization form is required per Salem State University policy and is in accordance with the Massachusetts College Immunization Law 105 CMR 220.600. **The student is responsible for verifying immunization compliance**.

Specific program requirements may be required for your major. Physical examinations are strongly recommended for students, but not required by counseling and health services. Please contact your specific department for relevant information.

Registration for classes, as well as the ability to move onto campus, will be affected if this information is not complete. Counseling and health services will not be able to individually notify students of their compliance status.

Health Form Return Options

Submit your health form on our health services portal **chsportal.salemstate.edu**.

- Log into the portal from Navigator
- Click on Immunization
- Click on Add Immunization Records
- Upload all photos of your immunizations
- Click on Save Records

Personal Information

Name _____
Last First Preferred Name Biological Sex Gender

Permanent Address _____
Street City State Zip Code Country

Date of Birth _____/____/_____ _____
Month Day Year Birthplace (Country)

_____
Student Home Phone Student Cell Phone Mobile Phone Carrier

Date Entering SSU _____/_____ ☐ Incoming Freshman ☐ Transfer Student
Month Year

This form can be accessed via counseling and health services' (CHS) website. Please log into the Health Services Portal to review and confirm that your information has been submitted.

The student health portal is where you can input your health information, access it for future use, as well as receive secure messages from our office.

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Medical Information and History

Name of Student

Date of Birth

Student ID #

This section to be completed by the student or parent/guardian.

Medical Information

Please provide the following information or a copy of your last physical (please note that the following information can be obtained via a nurse's visit):

Weight _____ Height _____

Allergies: Please specify, include allergies to medications, foods, seasons, animals, etc., and the types of reaction. _____

_____

Medications: Please list all medications that you are presently taking, including: vitamins, prescription and non-prescription medications, birth control, topical creams, inhalers, nasal sprays.

_____

_____

Operations / Hospitalizations, Injuries, Accidents: Provide details including dates, diagnoses, surgeries, etc. _____

_____

Health Issues: Do you have any health problems or additional information we should be aware of? If yes, please explain: _____

Personal Medical History

Check any and all, current or past conditions:

✔	Condition	✔	Condition	✔	Condition
	ADD		Fainting / Syncope		Mononucleosis
	ADHD		GERD / IBS		Neurologic Disorder
	Anemia		Gynecologic Problems		Respiratory Disease
	Anxiety		Head Injury /Concussion		Seizure Disorder
	Arthritis		Hearing Impairment		Sinus Infection (chronic)
	Asthma		Heart Disease		Skin Condition
	Blood Clots		Heart Murmur		Testicular Problem
	Cancer		High Blood Pressure		Thyroid Disease
	Crohn's / Colitis		Jaundice/Liver Disease		Tobacco Use
	Depression		Kidney Disease		Tuberculosis/TB+ Screening
	Diabetes		Migraines		Urinary Tract Infection
	Eating Disorder		Mobility Impairment		Vision Impairment

Consent for Treatment

The consent for treatment is to be carefully reviewed and then signed by the student and a legally authorized parent/guardian if under 18 years of age.

I consent to treatment by Salem State University counseling and health services staff while I am enrolled at Salem State University. I understand that there is no charge to be examined by a provider at student health services. However, I also understand that I and/or my insurance plan may incur charges for additional medical services including (but not limited to) lab tests, radiology tests, prescription medications, and ambulance transportation. I understand that my insurance will be billed for medical visits at health services. I understand the mandatory SSU fee will be used as my co-pay and no additional charges will be billed.

_____

Student Name (please print) Date of Birth

_____

Student Signature Date

For students under age 18:

_____

Parent/ Guardian Name (please print) Signature Date

Salem State University

Health Form
Immunization Record

Name of Student

Date of Birth

Student ID #

The health care provider must complete this immunization record OR attach a copy of the student's immunization record on office stationery.

In accordance with the Massachusetts College Immunization Law, Salem State University requires verification of immunity against certain illnesses. Exact dates are required for all immunizations and/or serologic test results, as well as any documented illnesses. If serology titers indicate lack of immunity, vaccines must be administered. **The student is responsible for verifying immunization compliance. Registration for classes, as well as the ability to move onto campus, will be affected if this information is not complete two weeks prior to moving onto campus and/or the start of your academic program.**

Required Immunizations and Health Information

Date of most recent physical examination
(please attach copy for athletic department or health service majors)
Month / Day / Year _____ / _____ / _____

Hepatitis B
- 3 doses required for 20 mcg series
- Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 weeks apart; at least 16 weeks between Doses 1 and 3

OR
- Hepatitis B Immune Serology (titer) accepted
- Lab documentation is attached

3-dose series **Month / Day / Year**
Dose 1 _____ / _____ / _____
Dose 2 _____ / _____ / _____
Dose 3 _____ / _____ / _____
OR
☐ Lab documentation is attached

Tetanus-Diphtheria and Pertussis (Tdap)
- 1 dose of Tdap within the past 10 years

Month / Day / Year
Tdap _____ / _____ / _____

Measles, Mumps, Rubella (MMR)
- 2 doses MMR
- Dose 1 after 1st birthday; Dose 2 at least one month after Dose 1

OR
- MMR immune Serology (titer) accepted
- Lab documentation is attached

Month / Day / Year
MMR Dose 1 _____ / _____ / _____
MMR Dose 2 _____ / _____ / _____
OR
☐ Lab documentation is attached

Meningococcal Vaccine
(required for full-time students 21 years of age or younger)
- MCV-4 conjugate vaccine (Menactra or Menveo)
  Dose received on or after 16th birthday

OR
- MPSV4-polysaccharide vaccine (Menomune or Mencevax)
  Dose received on or after 16th birthday

OR
- Signed waiver is attached (found on CHS website)

Month / Day / Year
MCV4 _____ / _____ / _____
OR
MSPV4 _____ / _____ / _____
OR
☐ Waiver is attached

Varicella (Chicken Pox)
- 2 doses of Varicella required
- Doses 1 and 2 at least 4 weeks apart

OR
- History of disease

OR
- Varicella Immune Serology (titer) accepted
- Lab documentation is attached

Month / Day / Year
Dose 1 _____ / _____ / _____
Dose 2 _____ / _____ / _____
OR
History of Varicella Disease _____ / _____ / _____
OR
☐ Lab documentation is attached

Recommended for all students. Document the following vaccines if you have received:

Immunizations	Date of Dose #1	Date of Dose #2	Date of Dose #3
Meningits B –Trumenba			
Meningits B – Bexsero			
HPV			

This page must be signed ONLY by a Health Care Provider or their authorized representative.

Health Care Provider Name (print)

Provider Signature _____ Date _____

Address _____ Phone Number _____

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Health Form

Tuberculosis Risk Questionnaire

Name of Student

Date of Birth

Student ID #

PART 1: TUBERCULOSIS (TB) SCREENING QUESTIONNAIRE (TO BE COMPLETED BY INCOMING STUDENTS)

Have you ever had close contact with persons known or suspected to have active TB Disease? ☐ Yes ☐ No

Were you born in one of the countries listed below that have a high incidence of active TB disease? ☐ Yes ☐ No
(If yes, please circle the country below)

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS				
Afghanistan	Comoros	Iraq	Nauru	South Africa
Algeria	Congo	Kazakhstan	Nepal	South Sudan
Angola	Cote d'Ivoire	Kenya	New Caledonia	Sri Lanka
Anguilla	(DPR of) Korea	Kiribati	Nicaragua	Sudan
Argentina	(DR of) Congo	Kuwait	Niger	Suriname
Armenia	Djibouti	Kyrgyzstan	Nigeria	Swaziland
Azerbaijan	Dominican Republic	Lao (PDR)	Northern Mariana Islands	Syrian Arab Republic
Bahrain	Ecuador	Latvia	Pakistan	Tajikistan
Bangladesh	El Salvador	Lesotho	Palau	Tanzania (United Republic of)
Belarus	Equatorial Guinea	Liberia	Panama	Thailand
Belize	Entrea	Libya	Papua New Guinea	Timor-Leste
Benin	Ethiopia	Lithuania	Paraguay	Togo
Bhutan	Fiji	Madagascar	Peru	Tunisia
Bolivia (Plurinational State of)	Gabon	Malawi	Philippines	Turkey
Bosnia and Herzegovina	Gambia	Malaysia	Portugal	Turkmenistan
Botswana	Georgia	Maldives	Qatar	Tuvalu
Brazil	Ghana	Mali	Republic of Kora	Uganda
Brunei Darussalam	Greenland	Marshall Islands	Republic of Moldova	Ukraine
Bulgaria	Guam	Mauritania	Romania	Uruguay
Burkina Faso	Guatemala	Mauritius	Russian Federation	Uzbekistan
Burundi	Guinea	Mexico	Rwanda	Vanuatu
Cabo Verde	Guinea-Bissau	Micronesia (FS of)	Sao Tome and Principe	Venezuela (Bolivarian Republic of)
Cambodia	Guyana	Mongolia	Senegal	Viet Nam
Cameroon	Haiti	Montenegro	Serbia	Yemen
Central African Republic	Honduras	Morocco	Sierra Leone	Zambia
Chad	India	Mozambique	Singapore	Zimbabwe
China	Indonesia	Myanmar	Solomon Islands	
Colombia	Iran (Islamic Republic of)	Namibia	Somalia	

Source: World Health Organization Global Health Observatory, Tuberculosis Incidence 2015.
Countries with incidence rates of > 20 cases per 100,000 population. For future updates, refer to **www.who.int/tb/country/en/.**

Have you had frequent or prolonged visits* to one or more of the countries listed above with a high prevalence of TB Disease? (If yes, check the countries above) ☐ Yes ☐ No

Have you been a resident and/or employee of high-risk congregate settings? (e.g., correctional facilities, long-term care facilities, and homeless shelters) ☐ Yes ☐ No

Have you been a volunteer or health-care worker who served clients who are at increased risk for active TB disease? ☐ Yes ☐ No

Have you ever been a member of any of the following groups that may have an increased incidence of latent M. tuberculosis infection or active TB disease? ☐ Yes ☐ No
Medically underserved, low-income, or abusing drugs or alcohol

If the answer is YES to any of the above questions, Salem State University requires documentation of further evaluation.
If the answer to all of the above questions is NO, no further testing or further action is required.
*The significance of the travel exposure should be discussed with a health care provider and evaluated.

Tuberculosis Risk Questionnaire (continued)

TUBERCULIN (TB) HISTORY AND REQUIREMENTS

Students from countries in which TB is prevalent must have a T-Spot® (blood test) at Salem State University's Health Services department within four weeks of the first day of classes, if testing has not been done.

Check all Tuberculin screening tests you have had:

☐ PPD, Mantoux (skin tests) Date planted: _____ Date read: _____
Result: _____ mm of induration

☐ T-SPOT ® (blood test) Date: _____ Result: ☐ Positive ☐ Negative

☐ QuantiFERON®-TB Gold (blood test) Date: _____ Result: ☐ Positive ☐ Negative

☐ Chest X-Ray Date: _____ Result: ☐ Positive ☐ Negative

☐ History of treatment for Tuberculosis disease

Start Date: _____ Duration: _____

Type of Treatment: _____

☐ History of treatment for positive PPD without disease

Start Date: _____ Duration: _____

Type of Treatment: _____

This page must be signed ONLY by a Health Care Provider or their authorized representative.

Health Care Provider's Name (Print): _____

Provider's Signature: _____ Date: ____/____/_____

Address: _____

Phone Number: _____ Fax Number: _____

Salem State University

Student Health Insurance Information

Name of Student

Date of Birth

Student ID #

Please Note:
Copy the front and back of any and all insurance cards that cover the student and mail it to us along with this packet.

IMPORTANT: THE INSURANCE INFORMATION PROVIDED ON THIS FORM DOES NOT WAIVE THE SALEM STATE UNIVERSITY HEALTH INSURANCE PLAN.

Massachusetts state law requires all students who are enrolled in 9 or more credits each semester to have health insurance coverage from a U.S.-based company or participate in the health insurance program provided by their college or university. Students are required to either enroll in or waive the university's health insurance plan.

You will receive instructions on how to waive the insurance via your To Do List in Navigator. If you have questions about waiving the health insurance, please contact the Navigation Center at 978.542.8000."

Health Insurance Information

If purchasing health insurance through the university, write "school plan" for insurance name and the rest will be completed later.

Some students may have a medical insurance policy that is separate from a prescription insurance policy. Students should carry their insurance card(s) or a copy with them at all times.

Insurance Company Name	Insurance Company Address	Telephone
Name of Policy Holder/Subscriber	Policy Holder's Date of Birth	Relationship to Student
Insurance Policy Number	Insurance Start Date	Group Number
Primary Care Physician Name	Phone Number	Fax Number

☐ **I have included a photocopy (front and back) of my health insurance card and have attached it to this form.**

Fees for Student Health Services

Undergraduate tuition pays for the services offered by Salem State University counseling and health services (CHS). You do not need to purchase the school health insurance plan in order to receive health care at CHS. The SSU college fee will be applied towards my visit, which means there are no office fees or co-pays for patient visits to CHS. However, you or your insurance plan may incur charges for additional medical services including (but not limited to) lab tests, radiology tests, prescription medications, ambulance transportations, or referral to specialists.

Before You Arrive at Salem State University

In order to avoid billing issues at the time of care, we ask you to contact your health insurance company now about payment for possible out of network benefits coverage, should the need arise. Insurance will be billed for medical visits at health services. The mandatory Salem State fee will be used as your co-pay and no additional charges will be billed. We recommend you call the insurance customer/member services number on your health insurance card and explain that you are a college student and need to know whether "medically necessary services" ordered by a Salem State University nurse practitioner or physician will be covered by your insurance, this may include vaccinations. CHS uses Quest Diagnostics (Cambridge, MA) for lab work and North Shore Medical Center's (Salem Hospital) radiology department to provide x-ray and radiology services. Please visit our billing web page for additional information.

Changes in Student Health Insurance During the Year

If your health insurance changes during the academic year, please copy the front and back of the new card and download this page from the CHS website to update. Then send the updated insurance information to counseling and health services immediately so we can add them to your records. Remember to check with your health plan regarding your new coverage.

Salem State University

Massachusetts Immunization Information System (MIIS)

FACT SHEET FOR PARENTS AND PATIENTS

The MIIS is a new statewide system to keep track of immunization records for you and your family. These records list the vaccinations (shots) you and your children get to protect against measles, chickenpox, tetanus, and other diseases. The goal is to make sure that everyone in Massachusetts is up-to-date with their shots and that your records are available when you need them – such as when your child enters school, when you need emergency medical help, or when you change healthcare providers.

How will it help me?

The MIIS:

- Helps you and your family get the best care wherever you go for your healthcare.
- Makes sure that you and your children don't miss any shots or get too many.
- Can print a record for you or your children when you need it – if you move, if your doctor retires, or when your child starts school or camp.

What is the MIIS?

- A computerized system that collects and stores basic immunization information for people who live in Massachusetts.
- A secure and confidential system, as required by Massachusetts law.
- A system that is available for people of all ages, not just children.

Why is this important?

As you know, the schedule of shots needed to keep healthy can be very complicated. The MIIS:

- Helps your healthcare provider keep track of which shots are due and when they should be given.
- Keeps all your immunization records together for you, your family, and your healthcare provider.
- Provides proof of vaccination for your children.
- Helps prevent outbreaks of disease like measles and the flu in your community.
- Keeps shot records safe during natural disasters such as flooding or hurricanes.

How can I get more information?

Please visit our website at www.mass.gov/dph/miis, contact the Massachusetts Immunization Program directly at 617.983.6800 or 888.658.2850, or ask your healthcare provider for more information.

What information is kept in the MIIS?

A list of shots that you or your children have received as well as any that you or your children get in the future. Information needed for safe and accurate immunization of each patient, such as:

- Full name and birth date
- Gender (male or female)
- Mother's maiden name (for children)
- Address and phone number
- Provider office where each shot is given

How does this information get into the system?

- Information about children is added when a child is born or when a child gets his or her first shots.
- Your healthcare provider can add your records or your family's records if they are not already in the MIIS.
- Who has access to my records?
- The Department of Public Health
- (DPH) uses modern technology to make sure that all information entered into the MIIS is kept secure and confidential.

The information in the MIIS is only available to:

- Healthcare providers or others ensuring appropriate immunization, as authorized by DPH
- Schools
- Local boards of health
- DPH, including the WIC program, and other state agencies or programs that provide education and outreach about vaccines to their clients
- Studies specially approved by the Commissioner of Public
- Health which meet strict legal safeguards

What if I don't want my information shared?

- You have the right to limit who can see your information.
- To limit who can see your information, you need to fill out the 'Objection or Withdrawal of Objection to Data Sharing' form which you can get from your healthcare provider.
- If you decide to limit who can see your information, your current healthcare provider will be able to see the shots they have given to you or your children, but may not be able to see your complete immunization history.
- If you decide to limit who can see your information, you will not have access to all of the benefits of the MIIS, like sharing your immunization records with schools and emergency rooms, and a complete record of shots in a single place.
- You can change your mind (decide to share or not share your information) at any time.

SHARING YOUR IMMUNIZATION INFORMATION

Objection (or Withdrawal of Objection) Form

The Massachusetts Immunization Information System (MIIS) keeps track of all immunizations which doctors and health care providers give to patients in Massachusetts. The system has been created according to state law (M.G.L c. 111, Section 24M), and is operated by the Massachusetts Department of Public Health (MDPH). All information in the MIIS is kept confidential.

The law requires that immunizations be reported to the MDPH through the MIIS. It allows for the information to be shared among doctors and nurses providing your care, school nurses, local boards of health, and staff at state agencies involved with immunization (including the WIC Program). The MIIS enables a new health care provider to check what shots you or your child have received in the past from other providers. Your records will only be available to those involved in your care, who have a reason to know about them. You have the right to limit who else may see your or your child's information in the MIIS. If you prefer that your or your child's immunization history not be shared in this way, you need to object to sharing your or your child's immunization information. If you have changed your mind or if you change your mind in the future and decide to share the information with more healthcare providers, you will need to withdraw your previous objection to sharing your or your child's immunization information.

What it means to Object to the sharing of your or your child's immunization information:

- Your or your child's immunization history will not be seen by all healthcare providers in the MIIS.
- Your or your child's immunization information will still be in the MIIS, but only the provider(s) who gives you shots and the Department of Public Health will be able to see it.
- Please note: you will need to keep track of your or your child's immunization records in the event that you change doctors or get immunizations from other health care providers.

To object to the sharing of your child's immunization information, follow these two steps:

- Contact your healthcare provider, health services at Salem State University or go to mass.gov/eohhs/doc/dph/cdc/immunization/miis-objection-form.pdf
- Give the completed form to your healthcare provider, health services at Salem State, or send, per instructions on the form, by fax or mail to the Massachusetts Department of Public Health.

What it means to withdraw a previous objection to sharing your or your child's immunization information:

- You have changed your mind and decide to share your or your child's information with all of your or your child's healthcare providers who are using the MIIS.
- Once the Withdrawal has been processed your records will be made available to individuals involved in your care, who have a reason to know about them.
- **How to withdraw a previous objection:**
    - Check "I WITHDRAW MY PREVIOUS OBJECTION" and complete the information requested.
    - Give the completed form to your healthcare provider or send by fax or mail to the Department of Public Health at the contact information provided.

You are considered a consenting participant in the MIIS system. If you object to being a participant, you must come to Counseling and Health Services, Ellison Campus Center, Room 107, to complete an objection form that will be kept on file with Counseling and Health Services and on file with MIIS.