

UNIVERSITY OF MASSACHUSETTS DARTMOUTH HEALTH SERVICES

A Division of Student Affairs

Congratulations on your acceptance to UMass Dartmouth.

The enclosed health form can very simply be filled out and returned by:

- **Step 1:** Answer the questions on pages 1, 3 and 4. *Note: On page 4 if you answer YES to any of the questions then you must then have your health care provider fill in the TB section on page 2. If your TB information is not documented, your Health Form will be considered incomplete.*
- **Step 2:** Attach a copy of your immunization record that is available from your High school or previous college. **Please send copies only as we will destroy the originals once the dates are entered into our database.**
- **Step 3:** *ALL full-time and part-time New Residential students* must read the Department of Public Health's information about bacterial meningitis. See the PDF on our site:

<http://www.umassd.edu/studentaffairs/health/healthfiles/meningitiswaiver.pdf>

If you decide that you want the vaccine, your health care provider must fill in the date you received the vaccine on Page 2 of the Health Form and sign the form or submit proof of this vaccine on a form from your health care provider.

If you are unsure, or your meningitis vaccine will be delayed beyond the due date, please sign the waiver on the bottom of the DPH **meningitis form** and enclose it.

YOU CAN ALWAYS SUBMIT THE MENINGITIS VACCINE INFORMATION LATER. MASSACHUSETTS LAW REQUIRES THAT WE HAVE THIS INFORMATION IN ORDER FOR YOU TO LIVE ON CAMPUS.

- Step 4. Mail the completed health form to University of Massachusetts Dartmouth, Health Services, 285 Old Westport Rd., North Dartmouth, MA 02747

If you do not have a copy of your immunizations then you will need to see your health provider and have him/her fill out page 2 and sign it on the bottom of the page.

These requirements are due by June 1st for Fall acceptance and January 15th for Spring acceptance or 30 days after acceptance. Failure to comply will adversely affect your admission, resulting in a hold on your registration and residential students will not be allowed into the residence halls.

The Health Office DOES NOT require physicals.

Students participating in Intercollegiate Athletics will need a physical; the form is available from the Athletic Department.

To comply with our health requirements you must:

- 1. Complete and submit the Health questionnaire**
- 2. Submit the immunization record (Required by Massachusetts Law)**
- 3. Fill out the waiver on the bottom of the DPH meningitis form if you are not going to receive the Meningitis vaccine.**

Thank you for your early attention to these requirements.



UMass Dartmouth Health Services
 285 Old Westport Road
 No. Dartmouth, MA 02747

Office (508) 999-8982
Fax (508) 999-8985

Name: _____ Male Female Date of Birth: _____
 Permanent Address: _____ Student ID# _____
 _____ Birthplace (Country): _____
 Home Phone: (____) _____ Cell Phone: (____) _____ Email: _____
 Date Entering UMass Dartmouth _____ Entering as: Undergraduate Graduate
 Residential Commuter
 If you have been previously enrolled at UMass Dartmouth, please list the date you last attended: _____

PARENT/GUARDIAN/NEXT-OF-KIN INFORMATION (For contact in case of emergency)

Name: _____ Relationship: _____
 Address: _____
 Home Phone: (____) _____ Business Phone: (____) _____ Fax: (____) _____

ALTERNATE EMERGENCY CONTACT:

Name: _____ Relationship: _____
 Address: _____
 Home Phone: (____) _____ Business Phone: (____) _____

Only in the event of an emergency would this contact information be released to University Authorities.

PRIMARY CARE PROVIDER Name and Phone # : _____
 Insurance Coverage – Name of Company: _____
 Address: _____
 Subscriber Name: _____ I.D. # _____

CONSENT for MEDICAL CARE

SIGNATURE OF PARENT/GUARDIAN REQUIRED IF STUDENT IS UNDER 18 YEARS OF AGE, AND IS VALID UNTIL AGE 18.

I hereby grant permission to the Director of UMass Dartmouth Health Services, or authorized representatives to provide such medical care as my daughter/ son _____, may require while he/she is a student at UMass Dartmouth including examinations, treatment, immunizations, etc. This also includes referral to an outside provider, a local hospital, hospitalization, anesthesia and/or surgery should it be necessary in the event of serious illness or injury and I am unable to be reached.

Name of Parent / Guardian (print) _____ Signature: _____ Date: _____

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

Immunization requirements apply to all full time undergraduate and graduate students, as well as all part-time health science students, regardless of year of birth. All residential students must comply with required immunizations. This form must be completed and signed by a health care provider.

REQUIRED

A. TETANUS-DIPHTHERIA (Td) Month/Day/Year

Tetanus-diphtheria booster within the last ten (10) years. ____/____/____

B. TDAP Tetanus, Diphtheria, Pertussis ____/____/____

C. M.M.R. (MEASLES, MUMPS, RUBELLA) – 2 doses required

Dose 1 on or after 1st birthday. ____/____/____

Dose 2 at least one month after dose 1. ____/____/____

OR

1. MEASLES (Rubeola) – If given instead of MMR, 2 doses required.
Initial vaccines must be after 1967.

Dose 1 on or after 1st birthday. ____/____/____

Dose 2 at least one month after dose 1. ____/____/____

OR Positive Measles antibody titer (Attach lab report). ____/____/____

2. RUBELLA – If given instead of MMR, 2 doses required.

Dose 1 on or after 1st birthday. ____/____/____

Dose 2 at least one month after dose 1. ____/____/____

OR Positive Rubella antibody titer (Attach lab report). ____/____/____

3. MUMPS – If given instead of MMR, 2 doses required.

Dose 1 on or after 1st birthday. ____/____/____

Dose 2 at least one month after dose 1. ____/____/____

OR Positive Mumps antibody titer (Attach lab report). ____/____/____

D. VARICELLA VACCINE: ____/____/____ ____/____/____

OR Month/Day/Year Month/Day/Year

Immune Titer ____/____/____

Month/Day/Year

OR positive history of disease _____

E. HEPATITIS B VACCINE – 3 doses required

Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____

OR Positive Hepatitis B surface antibody ____/____/____

(Attach copy or serological confirmation of immunity)

Required Residential Students Only Effective 1/1/07
F. MENINGOCOCCAL VACCINE Date: ____/____/____
OR SIGN THE ENCLOSED DPH WAIVER FORM

ALL VACCINE INFORMATION IS DUE IN HEALTH OFFICE BY JUNE 1ST (FALL ADMISSION) OR JANUARY 15TH (SPRING ADMISSION)

UMASS DARTMOUTH STRICTLY ENFORCES ALL IMMUNIZATION LAWS

REQUIRED HIGH RISK ONLY

SEE PAGE 4 FIRST

A. TUBERCULIN SKIN TEST (Mantoux/Intermediate PPD)

Test must be read by a healthcare provider 48-72 hours after administration. If no induration, mark "0". Result of multiple puncture tests, such as Tine or Mono-Vac, are NOT accepted.

Date test administered: ____/____/____ Date test read: ____/____/____ Result ____mm of induration

INTERPRETATION OF TUBERCULIN SKIN TEST: (Please use table below) Negative Positive

RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis	10 mm or more
Traveled or lived for a month or more in a country that has a high rate of tuberculosis	10 mm or more
No risk factors (Test not recommended)	15 mm or more

B. If Tuberculin Skin Test is POSITIVE, now or by history, the following are required

1. **Date of positive PPD:** Date: ____/____/____

2. **Chest X-Ray:** *REQUIRED* (Attach report, NOT the X-Ray) Date: ____/____/____

Normal Abnormal (Describe) _____

3. **Clinical Evaluation:**

Normal Abnormal (Describe) _____

3. **Treatment:**

No Yes (Drug, dose, frequency, and dates) _____

RECOMMENDED

GARDASIL: ____/____/____ ____/____/____ ____/____/____

Females Age 11-26 Month/Day/Year Month/Day/Year Month/Day/Year

★ **REQUIRED** ★

HEALTHCARE PROVIDER SIGNATURE

IF YOU ARE ATTACHING A COPY OF AN IMMUNIZATION RECORD THEN SIGNATURE IS NOT REQUIRED

Date: ____/____/____

Phone: _____

FAX: _____

Name: _____

Student ID# _____

MEDICAL HISTORY

FAMILY HISTORY

	Age	State of Health	Age of Death	Cause of Death	Have any of your immediate relatives had any of the following:		
					Yes	Relationship	
Father					Alcohol/ Substance Abuse		
Mother					Cancer		
Brothers					Diabetes		
					Heart Disease		
Sisters					High Blood Pressure		
					Kidney Disease		
Spouse					Neuromuscular disorder		
Children					Mental Illness		
					Tuberculosis		

PERSONAL HISTORY (Do you have now or have you ever had: (Check all that apply)

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney disease/ stones | <input type="checkbox"/> Sickle cell disease |
| <input type="checkbox"/> Anorexia Nervosa/Bulimia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Learning disability | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Drug/Alcohol problems | <input type="checkbox"/> Loss of paired organ (eye, kidney) | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional/mental illness | <input type="checkbox"/> Malaria | <input type="checkbox"/> Positive TB test |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease/problem | <input type="checkbox"/> Migraines/chronic headaches | <input type="checkbox"/> Tuberculosis disease |
| <input type="checkbox"/> Blind/visual impairment | <input type="checkbox"/> Hepatitis (Type _____) | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcer/stomach problems |
| <input type="checkbox"/> Cancer/malignancy | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Neuromuscular disease | <input type="checkbox"/> Urinary Tract Infection |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Phlebitis/deep vein clot | (frequent/recurrent) |
| <input type="checkbox"/> Crohn's/Ulcerative Colitis | <input type="checkbox"/> Impaired mobility/paralysis | <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Oth- |
| <input type="checkbox"/> Deaf/hearing impairment | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Seizure disorder | |

PLEASE EXPLAIN ALL POSITIVE ANSWERS (with dates): _____

INPATIENT HOSPITALIZATIONS: Please list all medical/psychiatric hospitalizations, dates, and diagnoses: _____

MEDICATIONS: Please list all (prescription and over-the-counter) including birth control, asthma medications, antidepressants, herbal supplements, etc: _____

ALLERGIES: None Known Yes (If yes, please specify, including medications, insect venoms, foods, etc.) _____

 Type of reaction: _____

- Do you smoke cigarettes? Yes No Number per day? _____ For how many years? _____
- Do you drink alcohol? Yes No How often? _____ When you drink, how many do you usually have? _____
- Do you now or have you ever used recreational drugs? Yes No Which ones? _____ How often? _____
- Do you follow any diets? Yes No What Kind? _____ Are you concerned about your eating habits? Yes No
- How much do you weigh? _____ How Tall are you? _____ What is your desired weight? _____ lbs.
- Do you often have a feeling of being anxious, overwhelmed or depressed? Yes No
- Have you ever received treatment or counseling for an emotional problem? Yes No
- Are you currently in counseling/therapy? Yes No Dates of treatment: _____

Name: _____

Student ID# _____

Medical Evaluation for Latent Tuberculosis Infections

All students must answer the following questions:

1. Have you ever had a positive tuberculosis skin test? Yes No (If yes, have your health care provider fill out Page 2.)
2. To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis (TB)? Yes No
3. Were you born in one of the countries listed below? Yes No
4. Have you traveled or lived for more than one month in any of the countries listed below? Yes No

COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)

Afghanistan	China, Macao SAR	Indonesia	Namibia	Somalia
Algeria	Colombia	Kazakhstan	Nicaragua	South Africa
Angola	Comoros	Kenya	Niger	Sri Lanka
Argentina	Congo	Kiribati	Nigeria	Sudan
Armenia	Congo, DR	Korea	Niue	Suriname
Azerbaijan	Cote d'Ivoire	Kyrgyzstan	Northern Mariana Islands	Swaziland
Bahamas	Djibouti	Lao PDR	Pakistan	Tajikistan
Bangladesh	Dominican Republic	Latvia	Palau	Tanzania, UR
Belarus	Ecuador	Lesotho	Panama	Thailand
Benin	El Salvador	Liberia	Papua New Guinea	Togo
Bhutan	Equatorial Guinea	Lithuania	Paraguay	Turkmenistan
Bolivia	Eritrea	Madagascar	Peru	Tuvula
Bosnia & Herzegovina	Estonia	Malawi	Philippines	Uganda
Botswana	Ethiopia	Malaysia	Poland	Uzbekistan
Brazil	Gabon	Maldives	Portugal	Vanuatu
Brunei Darussalam	Georgia	Mali	Qatar	Viet Nam
Burkina Faso	Ghana	Marshall Islands	Romania	Wallis and Fortuna
Burundi	Guam	Mauritius	Russian Federation	Yemen
Cambodia	Guatemala	Mexico	Rwanda	Zambia
Cameroon	Guinea	Micronesia	Sao Tome & Principe	Zimbabwe
Cape Verde	Guinea-Bissau	Moldova, Rep.	Saudi Arabia	
Central African Republic	Guyana	Mongolia	Senegal	
Chad	Haiti	Morocco	Seychelles	
China	Honduras	Mozambique	Sierra Leone	
China, Hong Kong SAR	India	Myanmar	Solomon Islands	

YES TO QUESTIONS 2, 3, OR 4 – Requires that you have a tuberculin skin test. **HIGH RISK**
 (Mantoux / intermediate PPD) to check for latent tuberculosis infection.

NO TO ALL OF THE ABOVE QUESTIONS – Means that you are considered low risk for tuberculosis, **LOW RISK**
 and that a skin test should not be done



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