WELLESLEY COLLEGE

HEALTH SERVICES

FALL ADMISSION DUE DATE IS JULY 1
SPRING ADMISSION DUE DATE IS JANUARY 13

TIME SENSITIVE

Welcome to Wellesley College! All of us at the Health Service look forward to meeting you and attending 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 online health history of MyWellness and the contents of this printed packet in its entirety by the required deadline:
Fall Admission due date is July 1; 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 clinician. Please download all pages of this document and complete page 1, *Permission for Treatment*. This *Permission for Treatment* form must be completed and signed by your legal guardian if you will be under age 18 when you enter Wellesley College. 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 this printed packet to your health care provider's office for your clinician's review, completion, and signatures where indicated. These forms cannot be completed by a parent clinician.

Use the *Health Form Check List* to keep track of the required forms and documents. **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:

- Use your Wellesley College Domain name and password to log into ***MyWellness*** (http://www.wellesley.edu/Health/Services/incoming.html) to enter your health history information and immunizations using the immunization information you obtain from your clinician.
- 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 Office of Disability Services 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, physician assistants 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

WELLESLEY COLLEGE
HEALTH SERVICES

HEALTH FORM CHECK LIST

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

- ❑ Have you printed and reviewed the information on the Wellesley Health Service Website http://www.wellesley.edu/Health/Services/incoming.html for entering students?
- ❑ Are all dates in month/day/year format?
- ❑ Are all pages requiring signatures signed?
- ❑ Have you had a physical exam within one year of enrollment?
- ❑ Did your clinician complete and sign the Physical Examination, Tuberculosis Risk Assessment, and Immunization pages?
- ❑ Did your clinician give a recommendation for physical activity (page 3)?
- ❑ Did your clinician record lab values for the required blood work and urine test within one year of enrollment?
- ❑ Did you obtain all required lab tests and immunizations? If your immunization record is incomplete, make every effort to complete your immunizations with your clinician. If this cannot be done prior to submitting the required forms, arrangements must be made to receive immunizations or serologic titres at Wellesley College Health Service within 1 week of arriving to campus. Fees will apply.
- ❑ Have you entered your health history and immunizations into **MyWellness** http://www.wellesley.edu/Health/Services/incoming.html ?

Reminder: Incomplete forms will result in delay in obtaining your OneCard (ID swipe card) upon your arrival to campus. Failure to provide complete health information will result in blocked registration for your classes.

Wellesley College Health Service 106 Central Street, Wellesley, MA 02481 Tel 781.283.2810 Fax 781.283.3693 www.wellesley.edu/Health
Summer business hours Mon-Fri 10am-2pm

WELLESLEY COLLEGE

HEALTH SERVICES

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 Services and Stone Center Counseling Services. I hereby authorize 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.

STUDENT'S SIGNATURE DATE

STUDENT'S PRINTED NAME DOB: (MM/DD/YY) DATE

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 DOB: (MM/DD/YY) 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 DOB: (MM/DD/YY)

PARENT/GUARDIAN SIGNATURE DATE

PARENT/GUARDIAN PRINTED NAME DATE

WELLESLEY COLLEGE

HEALTH SERVICES

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, phyician assistants, 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 3 (physical examination and physical education limits)
- Please review the TB Questionnaire with the student (page 4); if you answer yes to any screening questions, please complete the TB Risk Assessment (page 5-6)
- Please review, complete and sign page 7 (required* and recommended** immunizations)
  A supplemental copy of a clinician's office immunization record may be submitted.

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

- Hepatitis B—completed series
- Completed primary DTap series
- Tdap (unless Td received within 5 years)
- Measles, Mumps, Rubella (MMR)—2 doses—1st dose on or after 1st birthday
- Varicella—2 doses, 1st dose on or after 1st birthday, clinician certified history or titre
- Meningitis (must specify Menactra or Menomune)—or completion of authorized waiver (page 9)

****Recommended immunizations:**

- Polio—completed series including booster after 4th birthday
- HPV Vaccine—3 doses (series can be completed at Wellesley)

* See CDC website for recommended vaccine schedule

The student will be responsible for returning your completed and signed forms to the Wellesley College Health Service by **July 1**.

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 the 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. For your convenience, our fax number is 781.283.3693.

Sincerely,

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

PHYSICAL EXAMINATION (Must be within one year of enrollment. Cannot be completed by parent clinician.)

STUDENT'S NAME: _____ DOB: (MM/DD/YY) _____

DATE OF EXAMINATION: (MM/DD/YY) _____

HEIGHT: _____ WEIGHT: _____ BLOOD PRESSURE: _____ PULSE: _____

LABORATORY TESTS:

HEMOGLOGIN OR HEMATOCRIT (VALUE REQUIRED) _____

URINALYSIS (VALUE 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	❑	❑	
HEAD, NOSE, SINUSES	❑	❑	
MOUTH, TEETH, GINGIVA	❑	❑	
EARS (CANALS, DRUMS)	❑	❑	
HEARING	❑	❑	
EYES (SEE ABOVE)	❑	❑	
THROAT, THYROID	❑	❑	
LUNGS, CHEST	❑	❑	
HEART	❑	❑	
BREASTS	❑	❑	
BACK	❑	❑	
ABDOMEN	❑	❑	
PELVIC (IF INDICATED)	❑	❑	
EXTREMITIES, JOINTS	❑	❑	
NEURO	❑	❑	

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

RECOMMENDATION FOR PHYSICAL EDUCATION AND ACTIVITY:

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.

Step 1

Tuberculosis Screening Questionnaire

For completion by <u>all students.</u>

_____

STUDENT'S NAME: DOB: (MM/DD/YY)

	YES	NO
1. Have you ever had a positive TB skin test?	❑	❑
2. Have you ever had close contact with anyone who was sick with TB?	❑	❑
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)	❑	❑
4. Have you ever traveled** to/in one or more of the countries listed below? (If yes, please CIRCLE the country/ies)	❑	❑
5. Have you ever been vaccinated with BCG?	❑	❑

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

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 one year of enrollment). Please complete Step 2, found on page 5.

If the answer to all of the above questions is NO, no further testing or further action is required. Please sign page 6.

WORLD HEALTH ORGANIZATION. GLOBAL TUBERCULOSIS CONTROL. WHO REPORT 2006.

Step 2

Tuberculosis Risk Assessment

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

Required if yes answer to any Tuberculosis screening questions.

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	❑	❑
2. Foreign-born from (or travel* to/in) a high-prevalence area (e.g., Africa, Asia, Eastern Europe, or Central or South America)	❑	❑
3. Fibrotic changes on a prior chest x-ray suggesting inactive or past TB disease	❑	❑
4. HIV/AIDS	❑	❑
5. Organ transplant recipient	❑	❑
6. Immunosuppressed (equivalent of > 15 mg/day of prednisone for >1 month or TNF-antagonist)	❑	❑
7. History of illicit drug use	❑	❑
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)	❑	❑
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)]	❑	❑
10. Does the student have signs or symptoms of active tuberculosis disease?	❑	❑

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

If all above answers are no, please sign page 6. If any question is answered yes, proceed to step 3 with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray, and sputum evaluation as indicated.

Step 3

TUBERCULOSIS RISK ASSESSMENT

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

Option 1 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 ❑

Option 2 Interferon Gamma Release Assay (IGRA)

DATE OBTAINED:____M____/____D____/____Y____(SPECIFY METHOD) QFT-G QFT-GIT OTHER_____

RESULT: NEGATIVE ❑ POSITIVE ❑ INTERMEDIATE ❑

DATE OBTAINED:____M____/____D____/____Y____(SPECIFY METHOD) QFT-G QFT-GIT OTHER_____

RESULT: NEGATIVE ❑ POSITIVE ❑ INTERMEDIATE ❑

Step 4 Chest x-ray: (Required if TST or IGRA is positive)

DATE OF CHEST X-RAY: ____M____/____D____/____Y____ RESULT: NORMAL_____ ABNORMAL_____

Dates of treatment for LTBI: _____

medication and dose _____

_____

CLINICIAN'S SIGNATURE DATE

_____

CLINICIAN'S PRINTED NAME

TST **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

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

Immunizations Required by MA law for Wellesley College Entry

Measles, Mumps, Rubella (MMR)
Combined MMR- 2 doses required:
Dose 1 given on or after 12 months of age — Date (mm/dd/yy): _____
Dose 2 given at least 4 weeks after first dose — Date: _____
OR
Serologic Titers (MUST provide copy of lab report)
Measles ❑ Immune ❑ Not Immune — Date: _____
Mumps ❑ Immune ❑ Not Immune — Date: _____
Rubella ❑ Immune ❑ Not Immune — Date: _____

Tetanus-Diptheria-Pertussis (Tdap)
Completed Primary Series required (date of final dose of DTP/Dtap) — Date: _____
AND
Tdap booster required within the past 10 years — Tdap Date: _____
(if no Tdap, Td booster within 5 years is acceptable) — Td Date: _____

Hepatitis B
Full 3 dose series required for all students — Hep B Dose 1 Date: _____
Specify if 2 adult dose alternate series given — Hep B Dose 2 Date: _____
Hep B Dose 3 Date: _____
OR
Serologic Titers for Hepatitis B Surface Antibody (MUST provide copy of lab report)
Hepatitis B ❑ Immune ❑ Not Immune

Meningococcal Vaccine
Menactra- Meningococcal Conjugate Vaccine — Date: _____
(2 doses preferred if dose 1 given at age 11-12) — Date: _____
OR
Menomune-Meningococcal Polysaccharide (must be within 5 years) — Date: _____
OR
Signed Waiver Attached (see page 9) — Date: _____

Varicella
Varicella- 2 doses required
Dose 1 given on or after 12 months of age — Date (mm/dd/yy): _____
Dose 2 given at least 4 weeks after first dose — Date: _____
OR
Serologic Titers (MUST provide copy of lab report) ❑ Immune ❑ Not Immune — Date: _____
OR
History of Chickenpox disease — Date (month/year): _____

Other Immunizations	Date Dose #1	Date Dose #2	Date Dose #3
HEPATITIS A			
HPV (GARDASIL)			
POLIO			
RABIES			
TYPHOID (INJECTABLE)			
TYPHOID (ORAL)			
JAPANESE ENCEPHALITIS			
YELLOW FEVER			
OTHER: (IE: FLU)			

Clinician's Signature: _____
(M.D., N.P, P.A.) (not parent clinician) DATE
Please print name & address if different from page 3

STUDENT'S NAME: _____ DOB: (MM/DD/YY)

WELLESLEY COLLEGE HEALTH SERVICE OFFICE USE ONLY

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
❑ Physical
❑❑❑ Hep B

❑ Tdap
❑ Td
❑ Polio
❑ Meningitis

❑ Measles
❑ Rubella
❑ Mumps
❑ Varicella

❑ Lab
❑ TB Assessment
❑ Waiver
❑ Referred to MD

❑ MD Review
❑ HS letter
❑ SC letter
❑ 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)

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