The Wellness Center
Forms and Information

You and your parents need to read the attached information carefully, and complete all necessary forms. (These required forms are also available on our website under the Wellness Center - Forms and Waivers). Massachusetts state law requires that the Wellness Center have your completed insurance and health information forms (including completed Massachusetts immunization forms) on file before you can move into the residence halls and attend classes.

Please complete and return the following forms as soon as possible and no later than July 15th for students entering in the fall and January 1st for students entering in the spring.

To be completed by a physician:

- Physical Examination
- Immunization Records
- Epi Pen form (if applicable)
- Controlled Substance Prescriber Authorization (if applicable-Bard Academy only)

Immunizations required for college students in Massachusetts may differ from your state of residency. If you are missing any of the required immunizations, you need to receive them prior to your arrival on campus. If your physician does not have your complete immunization record, please obtain records from your current school and/or previous provider.

To be completed by the student and their family:

With the exception of the Physical Examination and Immunization records, all forms should be completed by you and your family. Be thorough in completing all forms—the information you submit is necessary for us to care for you if you become ill on campus, and to support your ongoing health and well-being.

Please feel free to contact the Wellness Center directly if you have any questions at 413-528-7353 or wellnesscenter@simons-rock.edu or visit The Wellness Center on the college’s website.

Please return the completed forms to:

The Wellness Center
Bard Academy/Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 413-528-7353 F: 413-528-7358
wellnesscenter@simons-rock.edu
The following pages need to be filled out by the student and a parent or guardian (if the student is a minor) with the exception of the physical exam and the immunization records pages. If there are any changes to this information during the academic year, please notify the Wellness Center.

**STUDENT IDENTIFICATION**

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**NOTIFY IN EMERGENCY (Parent/Guardian)**

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<th>Last Name</th>
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<th>Relationship to Student</th>
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<th>Home Address of person to notify</th>
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INSURANCE INFORMATION

Students are required to purchase the Academy/College health insurance. A student’s home insurance will be used as necessary.

The student health insurance plan for this coming academic year is with Blue Cross/Blue Shield of Massachusetts. Further information about the plan can be found on the Academy/College website under the Wellness Center in the Living on Campus section.

Does the student have health insurance under a family or individual plan? ____ Yes ____ No

IF YES, PLEASE ATTACH A COPY OF THE INSURANCE CARD BELOW.

FRONT OF CARD HERE

BACK OF CARD HERE

SUBSCRIBER’S NAME: ___________________________ D.O.B. _____/____/____

INSURANCE COMPANY: ________________________ INSURANCE ID#: __________

Medical Alert/Medication Allergies

NONE □

__________________________________________

__________________________________________

__________________________________________

__________________________________________
Confidential Sharing Agreement and Consent for Treatment

Bard College at Simon’s Rock /Bard Academy assures that medical information will be regarded as confidential and shared only as necessary for the student’s immediate safety or as allowed by law. **Minor students (under 18 yrs.) cannot remain on campus** until Health Services receives a signed Consent for Treatment form.

I hereby give my permission for the medical staff of the Wellness Center at Bard Academy and Bard College at Simon’s Rock, and their off-site medical providers, to provide and share medical information as needed and appropriate for the medical treatment of my child during the time they are enrolled as a student at Bard Academy or Bard College at Simon’s Rock. Furthermore, I give my permission to Bard Academy and/or Bard College at Simon’s Rock to arrange for/or provide transportation for my child to receive medical treatment. In case of an emergency, I give my permission for transportation and treatment of my child at a medical facility which may include: ambulance transport, medical treatment, psychiatric evaluation and/or treatment, and when necessary, hospitalization.

I also understand counseling services are available for all enrolled college and academy students, and I give permission for my child to utilize counseling services while enrolled.

_________________________________________________________________/____/_______
Signature of Parent/Guardian (required if student is under 18 years of age) Date
Health Services at the Wellness Center

CONSENT AND INFORMATION FORM
(For student to read and sign)

General Information
The Wellness Center is available to all currently enrolled Bard College at Simon’s Rock/Bard Academy students. The Wellness Center is open Mon-Fri. 9am-5pm. The Wellness Center office is closed on weekends and during all school vacations.

Urgent Care and Emergency Services
The Wellness Center provides urgent care coverage for weekends and nights when school is in session through an on-call nurse. The on-call nurse can be contacted through the Resident Directors or Campus Safety.

Making appointments
Walk in appointments are always welcome and we will do our best to see you as soon as possible. Appointments can be booked through the Front Office Manager for a specific nurse or the physician.

Health Insurance/Cost
All medical care provided at the Wellness Center will be covered by the school health insurance. The school health insurance will cover medication prescriptions issued from the Wellness Center and outside providers with a copay which is charged to the student’s account. In the event you are referred to an outside provider or have an Emergency Room visit, your home insurance and the school health insurance will be billed. For further information regarding the school health insurance, contact Blue Cross Blue Shield at 1-888-753-6615 or online www.studentbluema.com.

Confidentiality
Privacy of your health information is one of our top priorities. Other than as described in Exceptions to Confidentiality, no one outside of the Wellness Center staff will have access to your medical information including parents, faculty, student life staff, other students, or school administration without a student’s explicit written permission. To maintain continuity of care, all Wellness Center staff will have access to your medical record. If you are referred to a medical provider outside of the Wellness Center, medical information regarding the specific referral will be shared with the outside provider. Basic medical information will be shared with insurance companies to facilitate billing. If the student and provider deem it necessary to share medical information with someone outside of the Wellness Center, a student will be asked to sign an authorization form to release the information. Voice mail and e-mail communications to students will not include personal health information to maintain privacy.

Collaborative Treatment and Shared Space
The Health and Counseling Services offices reside together in the Wellness Center in the Student Union. Our philosophy of practice assumes an integrated and whole person approach, which includes sharing relevant health information in order to create a coordinated plan to best support a student’s wellness.

Exceptions to Confidentiality
There are some exceptions to confidentiality. In situations in which there is evidence of a threat of serious harm to oneself or another, the medical staff is required to take action/disclose information to protect the person at risk of harm. When there is information about, or strong suspicions of physical or sexual abuse or neglect of a minor, this must be reported to the Department of Social Services. In certain legal situations, including court order, a medical provider may be required to disclose information. In addition, any time a student is admitted to the Emergency Room, the medical staff will contact the student’s parents. This is a policy of Bard College at Simon’s Rock/Bard Academy and is in the student handbook.

I have read and understand the information above.

Student Signature: ___________________________ Print Name: ______________________         Date: __________________

11-9-17
MEDICATION AGREEMENT

For students living on campus, it is often easier to have existing prescriptions filled at a local pharmacy. Lenox Village Integrative Pharmacy delivers medications to the Wellness Center on weekdays. There are other pharmacies available in Great Barrington, if students choose to obtain prescriptions independent of the Wellness Center.

STUDENT AGREEMENT FOR SELF- ADMINISTRATION OF MEDICATIONS

 I understand that I am responsible for following my doctor’s directions for taking my medications.
 I will safely store prescribed and over the counter medication(s) in my room while at school.
 I will keep the medication in the original pharmacy-prepared container/package so that it can be easily identified.
 I agree to contact an adult on campus if I have an issue with medication.
 I will NEVER share my medication with another student.
 I will report lost or stolen medication to Security or the Wellness Center immediately.
 I understand that if I do not follow the above agreements I may be subject to the College/Bard Academy’s disciplinary action.
 By signing below, I understand and agree that it is my responsibility to ensure that my prescribed medication(s) is/are being administered in accordance with my medical provider(s)’ order(s).

___________________________  ______________________  ________________
Student Signature                  Print Name                                                  Date

PARENTAL CONSENT FOR SELF-ADMINISTRATION OF MEDICATIONS

I give permission for my child to self-administer prescribed as well as over the counter medications. I understand and agree that it is my child’s sole responsibility to ensure that the medication(s) is/are being administered in accordance with the medical provider(s)’ order(s) or the manufacturer’s directions. I understand and agree that the Wellness Center is not responsible for my child’s failure to follow prescribing orders or for the consequences of such failure.

___________________________  ______________________  ________________
Parent/Guardian Signature                  Print Name                                                  Date

CONSENT FOR OTC MEDICATIONS

I give permission for my child to access over the counter medications (for example Tylenol, Ibuprofen, Benadryl) through Campus Life Staff or Campus Safety when the Wellness Center is closed.

___________________________  ______________________  ________________
Parent/Guardian Signature                  Print Name                                                  Date
PHYSICAL EXAM RECORD

Bard College at Simon’s Rock and Bard Academy requires from your medical provider a record of a physical exam within the last 12 months. Please have your history reviewed by your health care provider and have them fill out the information below. State regulation mandates that Health Services be in possession of relevant health records before a student assumes residency on campus. Include copies of any other records you feel pertinent.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Date of Examination</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>Weight</td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Pulse</td>
<td></td>
</tr>
</tbody>
</table>

Medication Allergies

ACTIVE medical/psychiatric issues:

Significant PAST medical/psychiatric issues:

Current Medications:

This individual has been prescriber an EpiPen: [ ] YES [ ] NO

If yes, EpiPen form must be completed and returned

Please check if normal and explain otherwise.

<table>
<thead>
<tr>
<th>HEENT</th>
<th>Lungs</th>
<th>Spine (Scoliosis)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck</td>
<td>Skin</td>
<td>Neuro</td>
</tr>
<tr>
<td>Cardiac</td>
<td>Extremities</td>
<td>Abdomen</td>
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</table>

Healthcare Provider Signature: __________________________ Print Name: __________________________

(must be non-family member)

Address: _________________________________________________________________________________________

Phone: __________________________ Fax: __________________________
**MASSACHUSETTS REQUIRED IMMUNIZATION HISTORY**

This form must be signed by a physician. The state of Massachusetts mandates receipt of health records BEFORE students reside on campus. Unimmunized or under-immunized students require a letter of explanation of medical or religious exemption.

**REQUIRED IMMUNIZATIONS:**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Required Doses</th>
<th>Doses Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>TETANUS/DIPTHERIA/ACELLULAR PERTUSSIS</td>
<td>Primary series completed</td>
<td></td>
</tr>
<tr>
<td>Tdap</td>
<td></td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>MEASLES, MUMPS, RUBELLA (MMR) 2 doses required.</td>
<td>MMR #1</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>MMR #2</td>
<td>MM/DD/YY</td>
<td></td>
</tr>
<tr>
<td>MENINGITIS VACCINE (MenACWY, Menactra)</td>
<td>1 dose required on or after 16th birthday</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>VARICELLA</td>
<td>#1</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>#2</td>
<td>MM/DD/YY</td>
<td></td>
</tr>
<tr>
<td>HEPATITIS B</td>
<td>#1</td>
<td>MM/DD/YY</td>
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<tr>
<td>#2</td>
<td>MM/DD/YY</td>
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<tr>
<td>#3</td>
<td>MM/DD/YY</td>
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**RECOMMENDED IMMUNIZATIONS**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Doses Details</th>
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</thead>
<tbody>
<tr>
<td>Human Papillomavirus Vaccine:</td>
<td>#1</td>
</tr>
<tr>
<td>#2</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>#3</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>Hep A:</td>
<td>#1</td>
</tr>
<tr>
<td>#2</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>Other:</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>Tuberculosis testing: A mantoux is only required for students determined to be at high risk for tuberculosis. A chest film is required for any positive PPD. PPD Date</td>
<td>MM/DD/YY</td>
</tr>
<tr>
<td>chest X ray</td>
<td>MM/DD/YY</td>
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**Physician’s Name** __________________________________________

**Physician Phone number** ____________________________  **Fax number** ____________________________

**Address** __________________________________________________

**Physician’s Signature** ____________________________  **Date** ____________________________
MEDICAL CONDITIONS

I have this “Med-Alert” Condition: ____________________________

I have been prescribed an EpiPen: Yes ☐ No ☐

If yes, EpiPen form must be completed by your physician and returned.

List Medication Allergies: _______________________________________

List Other Allergies: _____________________________________________

Acute Health Issues: _____________________________________________

Current Medications/supplements: _________________________________

SCREENING QUESTIONS

Provide details for any questions answered “YES”.

1. Does student have physical limitations? ☐ ☐

2. Is student receiving or has student ever received treatment or counseling for mental health issues? ☐ ☐

3. Has student had any surgeries, or hospitalizations, or serious illnesses? ☐ ☐

4. Does student have any health concerns that require assistance while on campus? ☐ ☐

If yes, explain: ________________________________________________

PERSONAL MEDICAL HISTORY

Check the box below if student has had any problems in the following areas. Comment on all checked boxes in the space provided (attach an additional sheet if needed).

☐ Childhood Illnesses (whooping cough, chicken pox, rheumatic fever, etc.):

☐ Neurological (headaches, migraines, seizures, head injury, paralysis, etc.):

☐ Ears, Nose, Throat, Mouth (ear infections, hearing loss, sinusitis, tonsillitis, dental issues, etc.):

☐ Eyes (visual impairment, contact lenses or glasses, infections, etc.):

☐ Heart (palpitations, dizziness, fainting, arrhythmia, high/low blood pressure, etc.):

☐ Lung (shortness of breath, chest pain, asthma, infections, cough, etc.):

☐ Student has had a positive skin test for tuberculosis (TB)

☐ Musculoskeletal (broken bones, dislocation, scoliosis, weakness, etc.):

☐ Gastrointestinal/Metabolic (abdominal pain, diarrhea, constipation, significant weight gain/loss, diabetes, thyroid, etc.):

☐ Genital/Urinary (Urinary tract infections, kidney stones, gynecological problems, etc.):

☐ Skin (rash, eczema, herpes, etc.):

☐ Psychological (ADHD, anxiety, mood disorder, eating disorder, sleep problems, etc.):

Please provide additional information on all checked boxes including diagnosis, treatment and dates. (Use separate sheet if necessary).
EpiPen Form
This form is to be completed by the physician prescribing the EpiPen.

Name of Student: ________________________________ Date of Birth: ________________________________

Identified allergens: __________________________________________________________________________

Date of first allergic reaction: __________________________________________________________________

Symptoms experienced: __________________________________________________________________________

Initial symptoms requiring EpiPen treatment: __________________________________________________________________________

Number and type of subsequent reactions: __________________________________________________________________________

Number of episodes when EpiPen was administered: __________ Date of most recent administration: __________

Have any allergic reactions required hospitalization? Yes □ No □ If yes, please describe:
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Has this student received training on self-administration of the EpiPen? Yes □ No □
If yes, date: __________ Have they ever self-administered the EpiPen? Yes □ No □

Method of allergy testing: Blood □ Skin □

Asthma: Yes □ No □

Current allergy treatment: __________________________________________________________________________
___________________________________________________________________________________________________

Other treatments to be administered?
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Is there any other information that may be useful in treating this student?
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Healthcare Provider Signature: ____________________________ Print Name: ________________________________

Date: ____________________________ Phone: ________________________________

If applicable, please return the completed form to:

The Wellness Center
Bard Academy/Bard College at Simon’s Rock
84 Alford Road, Great Barrington, MA 01230-1978
P: 413-528-7353 F: 413-528-7358
wellnesscenter@simons-rock.edu
Dear new students and families,

The state of Massachusetts has changed its immunization requirement for the 2018-2019 school year. For all college students, a dose of Meningococcal vaccine (Menactra, Men ACWY) must have been given on or after the 16th birthday. This is different from the former recommendation and may be different from your home state requirements and/or your primary care provider's usual practice.

What this means for your student is this:

- If your college student is less than 16 prior to entry as a first year, they will have had to have had one dose of Meningococcal vaccine prior to entry and will need another on, or shortly after, their 16th birthday. If you would like that to be done on campus, we can make those arrangements.

- If your college student is 16 or older at the time of arrival on campus as a first year, they will have had to have had a Meningococcal vaccine on or after their 16th birthday, regardless of when prior vaccination took place.

If your student has not yet had a precollege physical, please advise your primary care provider of this immunization requirement at that time. If you submit, or have already submitted, an immunization record that does not support this new recommendation, we will need to have the student reimmunized prior to coming here. Of note, there are no ill effects of receiving an additional vaccination. Additionally, the state offers the option of signing a waiver, available at this site, instead of being vaccinated.

Please let us know if there are any questions.

Sincerely,

Diane Piraino, MD
Campus Physician
Information about Meningococcal Disease and Vaccination
and
Waiver for Students at Residential Schools and Colleges

Massachusetts 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 quadrivalent meningococcal polysaccharide or conjugate vaccine to protect against serotypes A, C, W and Y 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 1,000-1,200 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 hard of hearing or deaf, have problems with their nervous systems, including long term neurologic problems, 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 most at risk for getting meningococcal disease?
High-risk groups include anyone with a damaged spleen or whose spleen has been removed, those with persistent complement component deficiency (an inherited immune disorder), HIV infection, those traveling to countries where meningococcal disease is very common, microbiologists and people who may have been exposed to meningococcal disease during an outbreak. People who live in certain settings such as college freshmen living in dormitories and military recruits are also at greater risk of disease from some of the serogroups.

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 caused by some of the serotypes contained in the quadrivalent vaccine, 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, quadrivalent meningococcal vaccine is a safe and effective way to reduce their risk of contracting this disease. In general, the risk of invasive meningococcal B disease is not increased among college students relative to others of the same age not attending college. However, outbreaks of meningococcal B disease do occur, though rarely, at colleges and universities. Vaccination of students with meningococcal B vaccine may be recommended during outbreaks.

Is there a vaccine against meningococcal disease?
Yes, there are 3 different meningococcal vaccines. Quadrivalent meningococcal conjugate vaccine (Menactra and Menveo) protects against 4 serotypes (A, C, W and Y) of meningococcal disease. Meningococcal serogroup B vaccine (Bexsero and Trumenba) protects against serogroup B meningococcal disease. Quadrivalent meningococcal polysaccharide vaccine (Menomune) is recommended for people age 56 and older with certain high-risk conditions. MDPH strongly recommends two doses of quadrivalent meningococcal conjugate vaccine: a first dose at age 11 through 12 years and a second dose at 16 years. Individuals in certain high risk groups may also need to receive 1 or more of these vaccines based on their doctor’s recommendations. In addition, adolescents and young

(See reverse side)
adults (16-23 years of age) may be vaccinated with meningococcal B vaccine, preferably at 16-18 years of age, to provide short-term protection for most strains of serogroup B meningococcal disease.

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.

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 a dose of quadrivalent 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 must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine at any time in the past (or a dose of quadrivalent meningococcal polysaccharide vaccine within the last 5 years), 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. Meningococcal B vaccines are not required and do not fulfill the requirement for receipt of meningococcal vaccine.

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 and elected to decline the vaccine.

While not required, MDPH strongly recommends that anyone up to 21 years of age who is entering college receive a second dose of quadrivalent meningococcal conjugate vaccine if their first dose was received before their 16th birthday, particularly if they are new residential students. College students who do not live in campus-related housing and want to reduce their risk for meningococcal disease may also choose to be vaccinated, though it is not required. Adolescents and young adults (16 through 23 years of age) may also be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short-term protection for most strains of serogroup B meningococcal disease. Talk with your doctor about which meningococcal vaccines you should receive.

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 these vaccines. 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 www.mass.gov/dph/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 quadrivalent 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)

 Provided by: Massachusetts Department of Public Health / Division of Epidemiology and Immunization / 617-983-6800
MDPH Meningococcal Information and Waiver Form

Updated October 2016