Northeastern University
University Health and Counseling Services

UNIVERSITY HEALTH REPORT

REQUIREMENT

Massachusetts law requires all University students to provide documentation of vaccination against Hepatitis B, Measles, Mumps, Rubella, Meningitis, Tetanus, Diphtheria, Pertussis, and Varicella and Tuberculosis Screening.

RECOMMENDATION

UHCS recommends the following immunizations: HPV, Influenza, Covid-19, Meningitis B, and Hepatitis A.

Keep a copy of the completed form for your records.

1. Please complete the information requested below.
2. Sign the consent form.
3. Have your primary care clinician complete the state-mandated immunization form. If preferred, you can submit an official electronic print out of the immunization record from your provider that is signed by the provider.
4. Return completed form to University Health and Counseling Services by email immunizations@northeastern.edu.

DEADLINES

July 31st prior to entering for the Fall term - UNDERGRADUATE STUDENTS
December 1st prior to entering for Spring term - UNDERGRADUATE STUDENTS
One month prior to entering - GRADUATE STUDENTS

The University Health Report is required for all in-person students in Massachusetts and California.

Please read the following directions carefully. Any student failing to provide the required immunization documentation will be prohibited from both registering and attending all classes.

ACADEMIC DEGREE: ☐ Undergraduate ☐ Graduate

DEMOGRAPHIC INFORMATION (Please print)

LAST NAME **FIRST NAME** **MIDDLE INITIAL**

HOME ADDRESS **STREET** **CITY** **STATE** **ZIP CODE** **COUNTRY**

DATE OF BIRTH (MM/DD/YYYY) **LOCAL CELL PHONE NUMBER**

PARENT/GUARDIAN NAME **PARENT/GUARDIAN TELEPHONE** **EMAIL**

EMERGENCY CONTACT NAME **EMERGENCY CONTACT TELEPHONE** **RELATIONSHIP**

SEX ASSIGNED AT BIRTH* ☐ Female ☐ Male

GENDER IDENTITY **NAME USED** **PRONOUNS USED**

**UHCS recognizes members of the Northeastern University community authentically identify. Some insurance companies and legal entities unfortunately do not. It is because of this that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.*

CONSENT FOR TREATMENT AT UHCS

CONSENT FOR STUDENTS 18 YEARS OF AGE AND OLDER

I give University Health and Counseling Services (UHCS) of Northeastern University permission to provide such medical or mental health care while I am student at the University, including examinations, treatments, immunizations, etc. This also includes referral to outside providers, a local hospital and/or hospitalization, anesthesia or surgery should it be necessary in the event of an emergency.

There is no cost for medical or mental health visits at UHCS. I understand that I may be charged for lab tests, imaging, prescriptions, specialist visits, and acute care visits. It is my responsibility to refer for my health insurance plan information for coverage of medical and mental health services.

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STUDENT NAME **SIGNATURE** **DATE**

CONSENT FOR STUDENTS UNDER 18 YEARS OF AGE

Signature of parent/guardian is required if student is under 18 years of age and is valid until student turns age 18.

I hereby grant permission for University Health and Counseling Services (UHCS) or Authorized Representative to provide such medical or mental health care as my child ___________________________________ (STUDENT NAME) may require while they are a student at Northeastern University, including examinations, treatments, immunizations, etc. This also includes referral to outside providers, a local hospital and/or hospitalization, anesthesia or surgery should it be necessary in the event of an emergency.

____

STUDENT NAME **SIGNATURE** **DATE**

____

PARENT/GUARDIAN **SIGNATURE** **DATE**

____

RELATIONSHIP

REQUIRED IMMUNIZATIONS

VACCINE	GUIDELINES	DATE ADMINISTERED MM/DD/YYYY	
Measles, Mumps, Rubella (MMR) COMBINED*			
Measles, Mumps, Rubella (MMR) Combined	Two doses required, or positive measles, mumps and rubella antibody titers. Doses must be given ≥ 28 days apart beginning at or after the first birthday. The MMR vaccines may be substituted with two doses of Measles, two doses of Mumps and two doses of Rubella vaccines (or positive titers).	Dose 1:	
		Dose 2:	
		Or positive titer:	
***OR Measles, Mumps, Rubella (MMR) SEPARATE**			
Rubeola (Measles)	Two doses required, or positive antibody titers. First dose must be given on or after the 1st birthday and second dose must be given ≥ 28 days after the first dose.	Dose 1:	
		Dose 2:	
		Or positive titer:	
Mumps	Two doses required, or positive antibody titers. First dose must be given on or after the 1st birthday and second dose must be given ≥ 28 days after the first dose.	Dose 1:	
		Dose 2:	
		Or positive titer:	
Rubella (German Measles) OR	Two doses required, or positive antibody titers. First dose must be given on or after the 1st birthday and second dose must be given ≥ 28 days after the first dose.	Dose 1:	
		Dose 2:	
		Or positive titer:	

REQUIRED IMMUNIZATIONS

<table>
<tr><th>VACCINE</th><th>GUIDELINES</th><th colspan="2">DATE ADMINISTERED
MM/DD/YYYY</th></tr>
<tr><td>Meningococcal Conjugate Vaccine (ACWY)*</td><td>One dose of MenACWY vaccine is required for all full-time students 21 years old and younger. Doses received before 16th birthday do not count for this requirement.
The Meningitis B vaccine does not meet the requirement.</td><td>Date administered on or after 16th birthday (for students 21 years old and younger):</td><td></td></tr>
<tr><td>*OR WAIVER (please check if applicable): ☐</td><td colspan="3">I have reviewed the Massachusetts Meningococcal Fact Sheet. I understand the risks of not being vaccinated and have signed the form and attached it to this health report.</td></tr>
<tr><td rowspan="4">Hepatitis B</td><td rowspan="4">Three doses required, or positive antibody titers.

Two doses of Heplisav-B given on or after 18 years of age are acceptable.</td><td>Dose 1:</td><td></td></tr>
<tr><td>Dose 2:</td><td></td></tr>
<tr><td>Dose 3:</td><td></td></tr>
<tr><td>Or positive titer:</td><td></td></tr>
<tr><td rowspan="3">Tetanus/Diphtheria/ Pertussis (Tdap)</td><td rowspan="3">Vaccine within the last 10 years is required. Td or Tdap must be given if greater than 10 years since Tdap. Tdap is required if no history of previous Tdap.</td><td>Most recent Tdap:</td><td></td></tr>
<tr><td colspan="2">or</td></tr>
<tr><td>Most recent Td:</td><td></td></tr>
<tr><td rowspan="4">Varicella (Chicken Pox)</td><td rowspan="4">Two doses required, or positive antibody titers.

The first dose must be given on or after the 1st birthday and second dose must be given ≥ 28 days after the first dose.
A medically verified date of disease or laboratory evidence of immunity is acceptable.</td><td>Dose 1:</td><td></td></tr>
<tr><td>Dose 2:</td><td></td></tr>
<tr><td>Or positive titer:</td><td></td></tr>
<tr><td>Or verified date of disease:</td><td></td></tr>
</table>

REQUIRED SCREENING

TEST	GUIDELINES
Tuberculosis (PPD)	Complete the Massachusetts Tuberculosis Risk Assessment included on page 8 in this packet. This risk assessment form is also sufficient for students located outside of Massachusetts.

If you answered, "Yes" to any of the Tuberculosis Risk Assessment Questions, please complete a Tuberculosis Skin Test or IGRA blood test.			
TEST	GUIDELINES		
Tuberculosis: PPD Skin Test or IGRA Blood Test	If you checked any of the three boxes on the Massachusetts Tuberculosis Risk Assessment, a Tuberculosis Skin Test (PPD test) or an IGRA blood test within the past 12 months is required.	PPD Skin Test Plant Date:	
		PPD Read Date: Read within 24 to 72 hours from plant date	
		PPD Result:	
		IGRA Blood Test Date:	
		IGRA Result:	
If the result of the PPD Skin Test or IGRA Blood Test is positive, a chest X-ray within five years and an annual Symptom Free Note from your provider is required.			
Chest X-ray	If the result of your PPD Skin Test or IGRA Blood Test is positive, a chest X-ray within five years followed by an annual Symptom Free Note from your provider is required.	Chest X-ray Date:	
		Symptom Free Note Date:	

RECOMMENDED IMMUNIZATIONS

The following vaccines are NOT required:

VACCINE	GUIDELINES	DATE ADMINISTERED MM/DD/YYYY	
Influenza	Submit documentation of flu shot administered during the current flu season (August 2023 - March 2024)	Seasonal Dose:	
Meningitis B	Bexsero: Two doses at least one month apart.	Dose 1:	
		Dose 2:	
	or		
	Trumenba: Three doses at 0, 3 and 6 month intervals.	Dose 1:	
		Dose 2:	
		Dose 3 (if applicable):	
Hepatitis A	Two doses administered at least six months apart.	Dose 1:	
		Dose 2:	
HPV	A two-dose schedule is recommended for people who get the first dose before their 15th birthday. In a two-dose series, the second dose should be given 6–12 months after the first dose (0, 6–12-month schedule). The minimum interval is five months between the first and second dose. If the second dose is administered after a shorter interval, a third dose should be administered a minimum of five months after the first dose and a minimum of 12 weeks after the second dose.	Dose 1:	
		Dose 2:	
		Dose 3 (if applicable):	

RECOMMENDED IMMUNIZATIONS

VACCINE	GUIDELINES	DATE ADMINISTERED MM/DD/YYYY	
COVID-19	Documentation of primary two dose series and one COVID-19 bivalent booster.	Dose 1:	
		Dose 2:	
		Bivalent COVID-19 booster:	

A health provider must sign this form to verify dates.

NAME (PLEASE PRINT) SIGNATURE DATE

ADDRESS TELEPHONE

Northeastern University
University Health and Counseling Services

University Health and Counseling Services

immunizations@northeastern.edu