



University Health and Counseling Services  
 135 Forsyth Building  
 Northeastern University  
 360 Huntington Avenue  
 Boston, MA 02115  
 617.373.2772 (voice)  
 617.373.2601 (fax)  
 617.373.5973 (TTY)

# Health Report

**Dear Student:**

The staff at University Health and Counseling Services (UHCS) welcomes you, and would like to introduce you to our services. We provide comprehensive primary medical and behavioral health care on campus. Please review our Web site at [www.northeastern.edu/uhcs](http://www.northeastern.edu/uhcs) to get an idea of all we offer.

**Please complete the information requested below, sign the medical consent form, and have your primary care clinician complete the state-mandated immunization documentation form on the back.**

**Undergraduate** students entering the University in the fall of 2008 must return the form by **June 27, 2008**. If you are entering in the spring of 2009, you must return the form by **December 5, 2008**. Graduate students must return the form no later than a month before entering.

With wishes for good health, UHCS staff.

LAST NAME (PLEASE PRINT)		FIRST NAME		MIDDLE INITIAL	
HOME ADDRESS	STREET	CITY	STATE	ZIP CODE	COUNTRY
DATE OF BIRTH (MM / DD / YYYY)		BIRTHPLACE (COUNTRY)		CELL PHONE NUMBER	
FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>	UNDERGRADUATE <input type="checkbox"/>	GRADUATE <input type="checkbox"/>	DATE OF ENTRY TO NORTHEASTERN _____	MAJOR _____
PARENT/GUARDIAN NAME		PARENT/GUARDIAN TELEPHONE		PARENT/GUARDIAN E-MAIL	
EMERGENCY CONTACT NAME		TELEPHONE		RELATIONSHIP	

**CONSENT FOR TREATMENT**

I give University Health and Counseling Services of Northeastern University permission to treat me for medical/psychiatric conditions while I am a student at the University.

STUDENT NAME (PLEASE PRINT)	SIGNATURE	DATE
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(Must be signed by parent if student is under 18 years of age upon arrival at Northeastern University)

PARENT/GUARDIAN NAME (PLEASE PRINT)	SIGNATURE
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RELATIONSHIP	DATE
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Please retain a copy of this form for your records. Please print carefully and legibly.

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_  
 DATE OF BIRTH (MM / DD / YYYY) \_\_\_\_\_

## Required Record of Immunity

FAILURE TO MEET THIS REQUIREMENT WILL RESULT IN DENIAL OF ENROLLMENT.

The following is the documentation of immunity required by Massachusetts college immunization laws and Northeastern University. Month, day, and year of administration are required for all vaccines.

1. **HEPATITIS B** series of three: the 2nd at least thirty days after the 1st, the 3rd at least five months after the 2nd.

1ST \_\_\_\_\_ AND 2ND \_\_\_\_\_ AND 3RD \_\_\_\_\_  
 MM / DD / YY MM / DD / YY MM / DD / YY  
 OR POSITIVE TITRE \_\_\_\_\_ RESULT \_\_\_\_\_ RANGE \_\_\_\_\_  
 MM / DD / YY

2. **TWO (2) MMR (MEASLES/MUMPS/RUBELLA)\*** 1ST \_\_\_\_\_ AND 2ND \_\_\_\_\_  
 MM / DD / YY MM / DD / YY

OR  
 TWO (2) **MEASLES\*** 1ST \_\_\_\_\_ AND 2ND \_\_\_\_\_ OR POSITIVE TITRE \_\_\_\_\_ RESULT \_\_\_\_\_ RANGE \_\_\_\_\_  
 AND MM / DD / YY MM / DD / YY MM / DD / YY  
 ONE (1) **MUMPS\*** 1ST \_\_\_\_\_ OR POSITIVE TITRE \_\_\_\_\_  
 AND MM / DD / YY MM / DD / YY  
 ONE (1) **RUBELLA\*** 1ST \_\_\_\_\_ OR POSITIVE TITRE \_\_\_\_\_  
 MM / DD / YY MM / DD / YY

\*Since 1968: after twelve months of age; thirty days apart if two doses are required.

3. **MENINGITIS:** MENACTRA \_\_\_\_\_ OR MENOMUNE \_\_\_\_\_  
 MM / DD / YY MM / DD / YY

PLEASE NOTE: The Commonwealth of Massachusetts permits students to decline the meningitis vaccine. The declination form is online at [www.uhcs.neu.edu](http://www.uhcs.neu.edu).

4. **TETANUS/DIPHTHERIA** WITHIN TEN YEARS PRIOR TO REGISTRATION \_\_\_\_\_ OR DTAP \_\_\_\_\_  
 MM / DD / YY MM / DD / YY

### REQUIRED FOR ALL BOUVÉ COLLEGE OF HEALTH SCIENCES STUDENTS – RECOMMENDED FOR ALL STUDENTS

5. **VARICELLA** POSITIVE TITRE \_\_\_\_\_ OR HX DISEASE \_\_\_\_\_ OR VACCINE 1ST \_\_\_\_\_ AND 2ND \_\_\_\_\_  
 MM / YY MM / YY MM / DD / YY MM / DD / YY

## Clinician's Signature

NAME (PLEASE PRINT) \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_