



Summer English Language Institute
 July 20 - August 16, 2003
 Boston, Massachusetts USA
 (617) 573 - 8677 <http://sls.suffolk.edu>

Medical Authorization and Immunization Record

APPLICANT INFORMATION

Family Name: _____ First (Given) Name: _____
 Parent or Guardian's Name (if under 18): _____
 Street Address: _____
 City: _____ State: _____
 Country: _____ Postal Code: _____
 Telephone (including country code) : _____
 Birth date (mm/dd/yy): _____ Male: _____ Female: _____
 Group Leader : _____ Agency : _____

INSURANCE COVERAGE

All international students studying at Suffolk University must show proof of health insurance coverage with a U.S. carrier. If the applicant does not have medical insurance that will cover his/her stay in the United States, please contact us for a list of companies that provide short term insurance.

Insurance Carrier: _____
 Carrier Address: _____
 Name of Policy Holder: _____

MEDICAL DISCLOSURE

Are you receiving any kind of treatment for a medical condition such as asthma, diabetes, a heart condition, high blood pressure, emotional, neurological, etc.? If so, what is the medical condition?

Are you taking any medications of any type? If so, what is the name of the medication?

Do you have any allergies? If so, to what are you allergic? Do you require an Epi-Pen?

Are there any other medical concerns that you would like to bring to our attention?

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship: _____
 Contact Address: _____
 Contact Telephone: _____
 Alternate Emergency Contact: _____ Relationship: _____
 Contact Address: _____
 Contact Telephone: _____



IMMUNIZATION HISTORY

Family Name: _____ First (Given) Name: _____

Birth date (mm/dd/yy): _____ Male: _____ Female: _____

Home address: _____

Home telephone: _____ Parent's Name: _____

Immunization Verification is mandatory in Massachusetts. This section must be completed and signed by a health care provider. If the required immunizations are not documented, registration will be denied.

Required

A. Tetanus-Diphtheria Received booster within the past ten years _____ mm/dd/yy

B. MMR (measles, mumps, rubella)
Dose 1 immunized on or after first birthday _____ mm/dd/yy
Dose 2 immunized one month after the first dose _____ mm/dd/yy

1. Measles - if given instead of MMR
Dose 1 immunized on or after first birthday _____ mm/dd/yy
Dose 2 immunized one month after the first dose _____ mm/dd/yy

OR

Immune titer. Actual titer value _____ mm/dd/yy

2. Rubella – if given instead of MMR _____ mm/dd/yy

OR

Immune titer. Actual titer value _____ mm/dd/yy

3. Mumps – if given instead of MMR _____ mm/dd/yy

OR

Immune titer. Actual titer value _____ mm/dd/yy

C. Hepatitis B

Dose 1 _____ mm/yy/dd

Dose 2 _____ mm/yy/dd

Dose 3 _____ mm/yy/dd

OR

Immune titer. Actual titer value _____ mm/dd/yy

Recommended

D. Tuberculosis – It is recommended that you have a TB skin test if you fall into one of the following high-risk categories.

1. Have you lived or spent time with anyone who possibly or definitely had tuberculosis?
2. Have you lived or traveled extensively outside the US within the past five years to countries with a high prevalence of tuberculosis?
3. Do you or anyone in your household have AIDS or HIV infection?
4. Do you or anyone in your household use intravenous drugs or any other street drugs?
5. Have you worked or lived in a potentially high-risk setting, such as a prison/jail, long-term care facility, homeless shelter, residential medical facility, etc?
6. Are you non-US born from a high prevalence area of the world, including – Africa, Asia except Japan, Central/South America, Mexico, Eastern Europe, Caribbean except Jamaica, USVI, St. Kitts & Nevis.

If you answered yes to one of the above questions, you should have a TB skin test.

Tuberculosis – PPD (Mantoux) test within the past year _____ mm/dd/yy

OR

Positive PPD, negative chest X-ray within the past year (give results) _____ mm/dd/yy

E. Varicella – history of disease _____ mm/dd/yy

OR

Vaccine dose 1 _____ mm/dd/yy

F. Meningitis – vaccine date _____ mm/dd/yy

Health care provider name: _____

Signature : _____

Address: _____