Dear MIT Student,

On behalf of MIT Medical, welcome to MIT.

MIT Medical provides healthcare for students, faculty, employees, retirees, and their families. Our on-campus team of more than 100 primary care and medical specialty providers will ensure that you receive high-quality medical and mental health care during your time at MIT.

As an MIT student, you are covered by the MIT Student Medical Plan, included with tuition. This allows you to use many of the services at MIT Medical with no additional charge or copay, including:

- Unlimited care by a primary care provider
- Urgent care (by appointment; hours 8 a.m.–8 p.m. Mon–Fri, 10 a.m.–4 p.m. Sat–Sun)
- Medical advice available 24/7 at 617-253-4481
- Stress management consultations
- Mental health and counseling services
- Women’s health services
- Laboratory and other diagnostic testing and X-rays

One key to staying healthy is to have a campus care provider—a clinician you can come to know and trust. We encourage you to select a provider in MIT Medical’s Primary Care Service, either a physician or nurse practitioner. Our clinicians have a wide range of educational backgrounds, subspecialties, academic appointments, and practice styles. Go to medical.mit.edu/choose to learn more about providers who are accepting new patients, and choose the one that’s right for you.

MIT is legendary for its challenges. New students, especially those from other cultures, often have a difficult time adjusting to life at MIT. If this happens to you, talk about it with your friends, your health care provider, or a counselor. There’s no charge to talk with someone in MIT Medical’s Student Mental Health and Counseling Services. We have a wide range of mental health professionals ready to help you adjust to life at MIT.

MIT has a strict confidentiality policy. MIT Medical will not share your medical information with family members (including parents), deans, or faculty, unless you give us written permission.

When you get to campus, take the time to get to know us. You’ll discover that each one of us is dedicated to your personal health and the wellbeing of the entire MIT community.

Shawn Ferullo, MD
Student Health Director

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Term  | Deadline
---  | ---
Summer | May 7, 2021
Fall   | July 23, 2021
Spring | January 21, 2022

Questions?
- See medical.mit.edu/reportfaq
- Call 617-253-1777
- Email medrpt@med.mit.edu

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Instructions

Please read the following directions carefully. Incomplete medical report forms will result in a registration hold.

- **ALL NEW UNDERGRADUATE STUDENTS** must complete pages 2–8. The physical examination must be dated within the 12 months preceding your MIT registration date.

- **ALL NEW GRADUATE STUDENTS** must complete pages 2–5. The physical examination is optional for graduate students unless you plan on participating in intercollegiate (varsity) sports; then the physical exam is required and must be dated within the 6 months preceding your MIT registration date.

- **NEW HEALTH SCIENCE & TECHNOLOGY (HST) STUDENTS** must complete pages 2–5. The physical examination for HST students is optional. All HST students must provide positive titer results for the following: measles, mumps, rubella, hepatitis B and varicella. A tuberculosis screening test is required for all HST students regardless of your answers to the questions on page 5.

- **VARSITY STUDENT-ATHLETES** must complete pages 2–9. Athletes must have a physical within 6 months of their sports start date (fall season date for spring sports) and must have a clinician complete the Sickle Cell Trait Status form (page 9).

- Massachusetts law requires documentation of immunity to certain infectious diseases. The form to request an exemption for religious or medical reasons can be found at medical.mit.edu/forms.

- You can find documentation of immunization dates at schools you’ve previously attended or your doctors’ offices.

- All new students, including those in the military and those returning after an absence of one academic year or longer, must submit the completed Medical Report Form by the deadline indicated on the form.

- Pre-entrance medical requirements are not associated with or covered by the MIT Student Health Plan.

- Keep a copy of the completed form for your records.

- **Mail, fax, or email the completed form** before the applicable deadline listed below to avoid a registration hold:

  **Mail:**  MIT Medical Department
  Health Screening
  77 Massachusetts Ave. E23-127
  Cambridge, MA  02139-4307

  **Fax:**  + (1) 617-253-4121

  **Email:**  We recommend that you email your documents securely via Zix, our preferred secure email service. Create an account at web1.zixmail.net/s/e7b=medical.mit, and send your documents to medrpt@med.mit.edu.

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Complete all questions on pages 2 and 3 of this form in English, then sign and date it. Please print or write legibly.

Term Deadline
Summer May 7, 2021
Fall July 23, 2021
Spring January 21, 2022

Questions?
• See medical.mit.edu/reportfaq
• Call 617-253-1777
• Email medrpt@med.mit.edu

Student information

MIT registration date (check one):
☐ June 2021  ☐ September 2021  ☐ February 2022
Program type (check one):
☐ Undergraduate  ☐ Graduate  ☐ Health Science & Technology (HST)

Surname (family name)                      First name (given name)

Date of birth (month/day/year)  Age  Gender  MIT ID # (if known)

Home address

City, state, zip code  Country

Email address  Home phone  Cell phone

Family health history

Family member  Age  In good health?  Known health problem(s)  Deceased?
Parent 1  ☐ yes  ☐ no
Parent 2  ☐ yes  ☐ no
Brother(s)  ☐ yes  ☐ no
Sister(s)  ☐ yes  ☐ no

Student health history

Height:  Weight:

Do you wear glasses or contact lenses?  ☐ yes  ☐ no  If yes, attach a copy of your prescription or formula.

Are you presently under medical care for a medical or mental health problem?  ☐ yes  ☐ no
If yes, describe the problem(s) and treatment:

List all medications that you are taking (including those prescribed by a health professional as well as any over-the-counter medications, vitamins, and/or herbal supplements). Include name and dosage.

History of serious illnesses and/or injuries (include dates):

History of surgeries and/or hospitalizations (include dates):
Student health history, continued

Have you ever been cared for by a mental health clinician?  ☐ yes  ☐ no
Have you ever been hospitalized for a mental health concern?  ☐ yes  ☐ no
Have you ever had a period of depression, anxiety, or irritable mood for most of the day, lasting for weeks?  ☐ yes  ☐ no
Have you ever been unable to do your school work because of stress, anxiety, or depression?  ☐ yes  ☐ no
Have you ever been so upset that you have harmed yourself, or been afraid that you might harm yourself?  ☐ yes  ☐ no
Have you ever felt very lonely, or do you worry about being very lonely at MIT?  ☐ yes  ☐ no
Have you ever restricted your eating or purged?  ☐ yes  ☐ no
Would you be interested in more information about MIT student mental health services?  ☐ yes  ☐ no
Would you like a clinician from MIT Student Mental Health & Counseling Services to contact you?  ☐ yes  ☐ no

Sports participation

Do you plan to participate in intercollegiate (varsity) sports?  ☐ yes  ☐ no
If yes, please list all intercollegiate (varsity) sports in which you plan to participate:

To be medically cleared for intercollegiate (varsity) sports participation, all students, both undergraduate and graduate, are required to have a pre-entrance physical examination within 6 months of their sports start date, and submit the Sickle Cell Trait Status form (page 9).

Allergies

List any allergies to medications and describe the reaction:  ☐ no known drug allergies

List any food or environmental allergies and describe the reaction:  ☐ no known food or environmental allergies

Are you presently taking allergy injections?  ☐ yes  ☐ no
Do you plan to continue those injections while attending MIT?  ☐ yes  ☐ no

If yes, please read the following:

Things to know if you currently receive allergy injections and plan to continue treatment while attending MIT:

• Evaluation with an MIT allergist is required before allergy shots can be administered at MIT Medical.
• Allergy extracts and orders must be shipped (not hand-carried) to MIT Medical.
• Contact the Allergy Service at MIT Medical at 617-253-4460 to schedule an appointment and get information about shipping your extract and orders.

Choosing an MIT Medical campus care provider: You may choose a provider (a physician or nurse practitioner) now or any time while you are part of the MIT community. However, we encourage students who have chronic medical conditions or concerns to choose a provider now, and to contact that clinician upon arrival at MIT. You can view information about clinicians and submit your choice at medical.mit.edu/choose

Sign here:
student signature  date signed (month/day/year)
### Documentation of Immunizations

A physician, physician assistant, registered nurse, or nurse practitioner who is not the student or a relative of the student must complete all questions in English and sign this page, or attach a signed copy of the student’s immunization record.

**Student’s surname (family name)**

**First name (given name)**

**Date of birth (month/day/year)**

Massachusetts state law, and MIT policy, require all students, regardless of age or gender, to submit documentation of immunity to certain infectious diseases. **HST students must provide serologic proof** of immunity for measles (rubeola), mumps, rubella, hepatitis B, and varicella.

For these infectious diseases, dates of immunization or serologic proof of immunity are required:

<table>
<thead>
<tr>
<th>Required immunizations</th>
<th>Immunization dates (month/day/year)</th>
<th>Serologic proof</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doses must be at least 30 days apart.</td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, and rubella</td>
<td>MMR vaccine</td>
<td>Positive IgG serologic test</td>
</tr>
<tr>
<td></td>
<td>date of first dose</td>
<td>Date of test (month/day/year)</td>
</tr>
<tr>
<td></td>
<td>date of second dose</td>
<td></td>
</tr>
<tr>
<td>Measles vaccine</td>
<td>date of first dose</td>
<td></td>
</tr>
<tr>
<td>Mumps vaccine</td>
<td>date of first dose</td>
<td></td>
</tr>
<tr>
<td>Rubella vaccine</td>
<td>date of first dose</td>
<td></td>
</tr>
</tbody>
</table>

| Hepatitis B | 3 doses required | | |
|             | date of first dose | date of second dose | date of third dose | | | | |

| Varicella — 2 doses or history of disease required | History of disease: | | |
| date of first dose | date of second dose | | | | | | |

| Immunization since 9/1/2011 required: | Immunization since student’s 16th birthday or signed waiver form required: | |
|--------------------------------------|---------------------------------------------------------------------| |
| TDAP (tetanus, diphtheria, and pertussis) | Meningococcal (serogroups A, C, W, Y) | If providing a signed waiver, include it when submitting this form (see pages 10-11). |
| date of most recent dose | date of immunization (must be on or after student’s 16th birthday) | |

<table>
<thead>
<tr>
<th>Recommended immunizations:</th>
<th>Immunization dates (month/day/year)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Influenza</th>
<th>date of most recent dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A (2-dose series)</td>
<td>date of first dose</td>
</tr>
<tr>
<td>Polio (latest booster dose)</td>
<td>date of latest dose</td>
</tr>
<tr>
<td>HPV (3-dose series)</td>
<td>date of first dose</td>
</tr>
<tr>
<td>Bexsero (Meningococcal serogroup B) (2-dose series)</td>
<td>date of first dose</td>
</tr>
<tr>
<td>Trumenba (Meningococcal serogroup B) (2-dose series)</td>
<td>date of first dose</td>
</tr>
</tbody>
</table>

| Certification by health care provider (required): | |
|----------------------------------------------------| |
| signature of physician/PA/NP/RN | printed name | date (month/day/year) |
Mantoux Tuberculin Requirement

All students must complete section A. If any of the answers to the questions in section A are “yes,” then a health care provider must complete Section B. If all answers to the questions are “no,” skip Sections B and C.

student’s surname (family name) ___________________________ first name (given name) ___________________________ date of birth (month/day/year) ___________________________

Section A — to be completed by student

Country of birth: __________________________________________

Have you ever had tuberculosis or had a positive tuberculosis test? □ yes □ no

To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? □ yes □ no

Were you born in one of the countries or territories listed on page 6, or have you traveled or lived for more than one month in any of these countries or territories? □ yes □ no

Are you a Health Science and Technology (HST) student in the Medical Engineering & Medical Physics (MEMP) program? □ yes □ no

If you answered yes to any of the above questions, you are required to submit a Mantoux 5TU PPD skin test and result or a copy of an Interferon gamma release assay (IGRA), e.g. T-spot or Quantiferon-Gold test result. The test must have been performed within six months prior to your MIT registration date. Have your health care provider fill out Section B.

If you have previously had tuberculosis or a positive tuberculosis test, have your health care provider fill out Section C.

Section B — to be completed by health care provider

• Multiple-puncture TB tests are not acceptable (tine, HEAF, etc.).
• History of BCG is not a contraindication to TB testing.

Mantoux 5TU
Test date: ___________ date (month/day/year) Result: ___________ result (mm)

OR

Interferon gamma release assay (IGRA)
Test date: ___________ date (month/day/year) Include a copy of test results.

Section C — to be completed by health care provider in the event of positive tuberculosis test or history of tuberculosis

1. Attach a copy of a report for a chest X-ray that was taken upon or after the positive result. The chest X-ray report must be written in English and dated within 12 months prior to entrance to MIT.

2. Did the student receive tuberculosis therapy? □ yes □ no
   • If yes, provide information about therapy: Start date: ___________ Completion date: ___________

3. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats, or weight loss? □ yes □ no
   • If yes, please describe: __________________________________________

Certification by health care provider (required)

signature of physician/PA/NP/RN ___________________________ printed name ___________________________ date (month/day/year) ___________________________
If you were born in any of the countries or territories listed below, or traveled/lived in any of these countries or territories for more than one month, you are required to submit a Mantoux 5TU PPD skin test and result or a copy of an Interferon gamma release assay (IGRA), e.g. T-spot or Quantiferon-Gold, test result (see page 5). The test must have been performed within six months prior to your MIT registration date.

Afghanistan
Algeria
Angola
Anguilla
Argentina
Armenia
Azerbaijan
Bangladesh
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cabo Verde
Cambodia
Cameroon
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR
Colombia
Comoros
Congo
Côte d’Ivoire (Ivory Coast)
Democratic Republic of the Congo
Djibouti
Dominican Republic
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Eswatini (formerly Swaziland)
Ethiopia
Fiji
French Polynesia
Gabon
Gambia
Georgia
Ghana
Greenland
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Lao People’s Democratic Republic
Latvia
Lesotho
Liberia
Libya
Madagascar
Malawi
Malaysia
Maldives
Mali
Marshall Islands
Mauritania
Mexico
Micronesia (Federated States of)
Moldova (Republic of)
Mongolia
Morocco
Mozambique
Myanmar (Burma)
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Niue
Northern Mariana Islands
North Korea (Democratic People’s Republic of)
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Portugal
Qatar
Romania
Russian Federation
Rwanda
São Tomé & Príncipe
Senegal
Serbia
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
South Sudan
South Korea (Republic of Korea)
Sri Lanka
Sudan
Suriname
Tanzania (United Republic)
Tajikistan
Thailand
Timor-Leste (East Timor)
Togo
Tokelau
Trinidad
Tunisia
Turkmenistan
Tuvalu
Uganda
Ukraine
Uruguay
Uzbekistan
Vanuatu
Venezuela
Viet Nam
Yemen
Zambia
Zimbabwe
Physical Examination

A physician, physician assistant, registered nurse, or nurse practitioner who is not the student or a relative of the student must complete all questions in English and sign this page. Physical examination must be within 12 months prior to registration date.

Student’s surname (family name) ___________________________  first name (given name) ___________________________  date of birth (month/day/year) ___________________________

History and Review of Systems

Please answer all questions. Check “Y” for yes or “N” for no. If yes, please explain on page 8 under “Explain abnormalities” or add an additional sheet for explanation if necessary.

Has the patient had:

<table>
<thead>
<tr>
<th>Has the patient had:</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Anemia</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Asthma</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Malaria</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Meningitis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Gum/tooth disease</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Eye/vision condition</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Ear, nose, or throat trouble</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>H/O appendectomy</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Physical Examination

Height: __________  Weight: __________  BMI: __________  Blood Pressure: __________  Pulse: __________

Please check each system below and indicate if it is normal or abnormal. If abnormal, please give details on page 8 under “Explain abnormalities.”

<table>
<thead>
<tr>
<th>System</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skín</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>HEENT</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Lymph nodes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Thyroid</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chest/lungs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Breasts</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Peripheral vascular</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Heart murmurs</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Abdomen</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

MIT Use Only — Intercollegiate sports participation

☐ Approved  ☐ Denied  ☐ Requires sports med physician review  INITIALS ______
Physical Examination, continued

Explain any abnormalities:

Do you feel the student has any condition that would warrant any accommodations while engaging in studies at MIT? If so, please explain:

Is this person under treatment for any medical or mental health condition? If yes, please describe the problem and treatment:

In your opinion, is there any contraindication for this person to participate in collision, contact, or non-contact sports? If yes, please describe the nature of your suggested limitation or your advice for further work-up:

Do you have any recommendations for this person’s health care while at MIT?

Certification by health care provider (required)

signature of physician/PA/NP/RN

printed name

date (month/day/year)

mailing address

Office phone
Sickle Cell Trait Status

Complete this form if you plan to participate in intercollegiate (varsity) sports. Submit this form with your physical examination.

Deadline
July 31 or before participation in intercollegiate sports

surname (family name) first name (given name) date of birth (month/day/year)

To be medically cleared for intercollegiate (varsity) sports participation, all students, both undergraduate and graduate, are required to have a pre-entrance physical examination within 6 months of the first day of participation for their sport, and submit this form.

About Sickle Cell Trait

• Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells.

• Sickle cell trait is a common condition.

• Although sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.

• Sickle cell trait is usually benign, but during intense, sustained exercise, decreased oxygen in the muscles may cause sickling of red blood cells (change from normal disc shape to a crescent, or “sickle,” shape). Sickled red blood cells can accumulate in the bloodstream and block blood vessels. This can lead to collapse from rapid breakdown of muscles without blood supply.

Sickle Cell Screening

• Sickle cell trait testing in the form of a sickle cell screen blood test should be done by the student-athlete’s primary care physician before coming to campus. If testing is not performed at home, you can request testing at MIT Medical. The NCAA requires that all student-athletes have knowledge of their sickle cell trait status before participation in any intercollegiate athletics event, including but not limited to; strength and conditioning sessions, practices, and competitions.

• If the student-athlete, and his or her parent/guardian if the student-athlete is a minor, does not desire sickle cell testing, a waiver must be signed. The Sickle Cell Waiver form is distributed to athletes by the Department of Athletics, Physical Education and Recreation (DAPER).

Sickle Cell Screening Results and Clinician Signature

Sickle cell screen date: result:

date (month/day/year) positive/negative

certification by health care provider (required)

signature of physician/PA/NP/RN printed name date (month/day/year)
Colleges: Massachusetts requires all newly enrolled full-time students 21 years of age and under attending a postsecondary institution (e.g., colleges) to: receive a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday to protect against serotypes A, C, W and Y or fall within one of the exemptions in the law, discussed on the reverse side of this sheet.

Residential Schools: Massachusetts requires all newly enrolled full-time students attending a secondary school who will be living in a dormitory or other congregate living licensed or approved by the secondary school or institution (e.g., boarding schools) to receive quadrivalent meningococcal conjugate vaccine to protect against serotypes A, C, W and Y or fall within one of the exemptions in the law, 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. Symptoms of meningococcal disease may appear suddenly. Fever, severe and constant headache, stiff neck or neck pain, nausea and vomiting, sensitivity to light and rash can all be signs of meningococcal disease. Changes in behavior such as confusion, sleepiness, and trouble waking up can also be important symptoms. Less common presentations include pneumonia and arthritis. In the US, about 350-550 people get meningococcal disease each year and 10-15% die despite receiving antibiotic treatment. Of those who live, another 10-20% 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 at most 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 who work with the organism 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?
In the 1990s, college freshmen living in residence halls were identified as being at increased risk for meningococcal disease. Meningococcal disease and outbreaks in young adults were primarily due to serogroup C. However, following many years of routine vaccination of young people with MenACWY vaccine, serogroup B is now the primary cause of meningococcal disease and outbreaks in young adults. Among the approximately 9 million students aged 18-21 years enrolled in college, there are an average of 20 cases and 2-4 outbreaks due to serogroup B reported annually.

Although incidence of serogroup B meningococcal disease in college students is low, college students aged 18-21 years are at increased risk compared to non-college students. The close contact in college residence halls, combined with certain behaviors (such as alcohol consumption, exposure to cigarette smoke, sharing food or beverages, and other activities involving the exchange of saliva), may put college students at increased risk. 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.

Is there a vaccine against meningococcal disease?
Yes, there are 2 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 conjugate vaccine is routinely recommended at age 11-12 years with a booster at age 16. Students receiving their first dose on or after their 16th birthday do not need a booster. Individuals in certain high risk groups may need to receive 1 or more of these vaccines based on their doctor’s recommendations. Adolescents and young adults (16-23 years of age) who are not in high risk groups 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. Talk with your doctor about which vaccines you should receive.
**Is the meningococcal vaccine safe?**
Yes. 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 vaccine, like any medicine, is capable of causing serious problems such as severe allergic reactions, but these are rare.

**Is meningococcal vaccine mandatory for entry into secondary schools that provide housing, and colleges?**
Massachusetts law (MGL Ch. 76, s.15D) and regulations (105 CMR 220.000) requires both newly enrolled full-time students attending a secondary school (those schools with grades 9-12) who will be living in a dormitory or other congregate housing licensed or approved by the secondary school or institution and newly enrolled full-time students 21 years of age and younger attending a postsecondary institution (e.g., colleges) to receive a dose of quadrivalent meningococcal conjugate 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. Secondary school students must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine at any time in the past, unless they qualify for one of the exemptions allowed by the law. College students 21 years of age and younger must provide documentation of having received a dose of quadrivalent meningococcal conjugate vaccine on or after their 16th birthday, regardless of housing status, unless they qualify for one of the exemptions allowed by the law. Meningococcal B vaccines are not required and do not fulfill the requirement for receipt of meningococcal vaccine. 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.

**Exemptions:** 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.

**Shouldn’t meningococcal B vaccine be required?**
CDC’s Advisory Committee on Immunization Practices has reviewed the available data regarding serogroup B meningococcal disease and the vaccines. At the current time, there is no routine recommendation and no statewide requirement for meningococcal B vaccination before going to college (although some colleges might decide to have such a requirement). As noted previously, adolescents and young adults (16 through 23 years of age) may be vaccinated with a serogroup B meningococcal vaccine, preferably at 16 through 18 years of age, to provide short term protection against most strains of serogroup B meningococcal disease. This would be a decision between a healthcare provider and a patient. These policies may change as new information becomes available.

**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)

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**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 conjugate vaccine. I understand that Massachusetts’ law requires newly enrolled full-time students at secondary schools who are living in a dormitory or congregate living arrangement licensed or approved by the secondary school, and newly enrolled full-time students at colleges and universities who are 21 years of age or younger 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: ________________

Signature: ________________________________________ Date: ________________

(Student or parent/legal guardian, if student is under 18 years of age)
Thank you for choosing to receive care at MIT Medical. MIT Medical is committed to protecting your privacy. Please review the following guidelines to understand how your information will be protected, disclosed and used at MIT Medical.

**Routine Uses and Disclosures of Your Information**

The federal Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of the health information that we collect about you. Health information is information that could be used to identify you and that relates to your health condition, your health care or payment for your health care. We are permitted to use health information for a variety of routine tasks, such as to provide health care services to you, obtain payments for those services and conduct normal health care business operations. Here are examples of how we use your health information:

- **Treatment** – We keep a record of each visit and/or admission. These records may indicate your test results, diagnoses, medications and response to medications or other therapies. A clinician at MIT Medical may share your health information with another clinician inside MIT Medical or with a clinician at another clinic or hospital, in order to determine how to diagnose or treat you. Your clinician may also share your health information with another clinician to whom you have been referred for further health care. This allows physicians, nurses and other clinical staff members to provide the best possible care to meet your needs.

- **Payment** – We keep a record of the services and supplies you receive at each visit and/or admission, so that we can be paid by you, an insurance company or a third party. We may tell your health plan about an upcoming treatment or service in order to obtain their prior approval and authorization.

- **Health care operations** – We use your health information to ensure the quality of the services we provide, for population health and other clinical data analysis activities, to train staff, for business and financial analysis or management and for customer service purposes. For example, we may use your health information to evaluate the performance of our staff in caring for you, or to educate our staff on how to improve the care they provide for you, or to ensure that you have received appropriate disease management and/or screening.

We may share your health information with your health plan only if you are a plan member and only to the extent necessary to obtain payment for your health care. Your health information may also be shared with our business associates to facilitate treatment, payment for services or health care operations. In any of these cases, the persons with whom we share your health information must follow HIPAA privacy requirements.

Massachusetts law provides additional privacy protection for certain types of information. As a result, some parts of this general Notice of Privacy Practices may not apply to, among others, HIV test information, alcohol and substance abuse treatment information, genetic information and mental health information. For example, state law requires our mental health providers to obtain your consent, under certain circumstances, before using or disclosing your mental health information for many of the purposes described above. For more information, please contact the MIT Medical Privacy Officer at 617-253-2320 or email privacy@med.mit.edu.

**Non-Routine Uses and Disclosures**

There are other times when we are allowed or required to use or disclose health information without your permission. These circumstances are:

- If required by law;
- For public health activities such as immunization information, tracking diseases or monitoring the effectiveness of drugs or the safety of medical devices;
- To protect victims of abuse, neglect or domestic violence;
- For health oversight activities, such as government audits of MIT Medical;
- For judicial or administrative proceedings, such as responding to subpoenas issued by parties to a lawsuit;
- For law enforcement purposes, such as complying with court orders or responding to law enforcement requests when you have been a victim of a crime;
- In the unfortunate event of your death, to coroners, medical examiners, funeral directors and organizations that procure or store organs and must determine if donation is possible;
- To avert serious threats to the health or safety of you, another person, or the public; but we will only share your health information with someone able to help prevent the threat;
- For specialized government functions, such as military, veterans, national security, and intelligence activities;
- To Workers’ Compensation if you are injured at work;
- To a correctional institution or law enforcement officer if you are an inmate or otherwise detained;
- For research purposes, so long as we have obtained, through a special process, assurance that research without your written authorization poses minimal risk to your privacy, or if the researcher has made certain specific promises to us about how your information will be used;
• To maintain a facility directory, so long as in non-emergency situations you have been given the opportunity to restrict or prohibit this disclosure;
• To friends or family members involved in your care or payment of your care, if you are incapacitated or otherwise unable to give consent and we determine that it is in your best interest to disclose, but we will always seek your consent if you are able;
• To public or private entities for disaster relief, unless you object and your objection does not interfere with the entities’ relief efforts;
• To persons who are legally authorized to act as your personal representative, unless circumstances are such that doing so is not in your best interest. A parent or guardian will generally be considered the personal representative of a minor child unless the child is permitted by law to act on his or her own behalf. MIT students are not considered minors, regardless of age; or
• As part of potential unavoidable disclosures that are incidental to otherwise permissible uses or disclosures, such as when other patients in a treatment area overhear some element of your health information in the course of a treatment session, given reasonable safeguards and other minimum necessary policies.

We may also use your health information to contact you about treatment alternatives and other health benefits and services that may be of interest to you, or to send you appointment reminder notices. However, to the extent a third party provides financial remuneration to us so that we make these treatment or healthcare operations-related communications to you, we will secure your authorization in advance. In addition we may remind you to refill your current prescription, or provide you with information regarding self-administration of certain medications, even if a third party pays the reasonable costs incurred by us to make this communication to you.

We may use your health information, in aggregate, to inform clinical, operational or financial analyses and improvements, but we will not disclose any personally identifiable information other than as described above.

All other uses and disclosures not described above may only be made with your written authorization. For example, most uses and disclosures of psychotherapy notes, most uses and disclosures of health information for marketing purposes and disclosures that constitute a sale of health information would all require your authorization. In addition, we would need your authorization to make disclosures to others at MIT who are not affiliated with MIT Medical (e.g., a Dean, a professor, the Provost, MIT Human Resources). MIT Medical also will not disclose health information to prospective employers without your written authorization. You may revoke any authorization you provide to us in writing at any time.

Your Rights

Under HIPAA, you have the right to:

• Request restrictions on how we use or disclose your health information in certain circumstances, including for treatment, payment or health care operations. We do not have to agree to your request unless you request restriction on disclosures to a health plan for purposes of payment or healthcare operations, and the health information relates to an item or service for which you, or another person on your behalf, have assumed full financial responsibility. If we do agree to your restrictions, we will be bound by our agreement except in limited circumstances, such as if there is an emergency.
• Request to receive confidential communications at an alternate phone number or address. Your request must be in writing. We will try to accommodate all reasonable requests.
• Request to inspect and obtain a copy of your health information (fees may apply). Your request must be in writing; download and complete the form at www.medical.mit.edu. Under certain circumstances, we have the right to deny your request consistent with HIPAA regulations.
• Request amendment to your health information if you feel you need to make additions or corrections. Your request must be in writing; download and complete the form at www.medical.mit.edu and include supporting information.
• Get an accounting of disclosures of your health information made during the six years prior to your request, except for disclosures we made to you, pursuant to your written authorization.
• Get a paper copy of this notice upon request, even if you received it electronically.

Our Responsibilities

We are required by law to retain medical records for at least twenty (20) years after the patient’s discharge or final treatment. For more information, you can request a copy of our medical record retention policy. We are also required to maintain the privacy of your health information, provide this written Notice of Privacy Practices, abide by the terms of the Notice currently in effect, and notify you following a breach of unsecured protected health information that affects you. We reserve the right to change our Notice of Privacy Practices and make the new provisions effective for all health information we maintain. Revised Notice of Privacy Practices will be available at www.medical.mit.edu and will be posted at our facilities.

MIT Medical is committed to protecting your privacy. Your health information is available to our employees in accordance with this Notice of Privacy Practices and applicable HIPAA regulations. Our employees must adhere to confidentiality policies designed to prevent any misuse of your health information.
Copies of Notice, Additional Information, Complaints

For copies of this Notice or additional information, visit www.medical.mit.edu, call MIT Medical's Privacy Officer at 617-253-2320, or email privacy@med.mit.edu. If you believe your privacy rights have been violated, you may file a complaint with MIT Medical and we will act promptly to investigate and resolve it. To file a complaint with MIT Medical, write to the Privacy Officer (E23-023, 77 Massachusetts Ave., Cambridge, MA 02139). You may also file a complaint with the Secretary of the Department of Health and Human Services. For more information on how to file a complaint with the Secretary, visit www.hhs.gov/ocr/privacy/hipaa/complaints. You will not be subject to any retaliation or other harm as the result of any complaint. Complaints must be filed in writing.

Acknowledgment (required)

I acknowledge receipt of this Notice of Privacy Practices.

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Financial Responsibility Guidelines

Thank you for choosing to receive care at MIT Medical. Please review the following guidelines to understand your financial responsibility for services received at MIT Medical.

Health Insurance, Including Medicare or Medicaid

As a patient of MIT Medical, it is important that you understand your health plan benefits and coverage rules, including referral and prior authorization requirements. It is also important that you understand what you are financially responsible for under your health plan prior to any visit, including applicable deductibles, coinsurance, co-payments and/or out-of-network charges. If you have questions about any of this information, you should contact your health insurance company or the Centers for Medicare and Medicaid Services (CMS) directly.

It is your responsibility to ensure that your (and/or your dependents') coverage is active prior to any visit. MIT Medical will work with you to confirm and validate your demographic and health insurance information at the time of your visit, but it is your responsibility to inform MIT Medical of any changes to this information prior to receiving services.

At MIT Medical, we recommend that all of our patients obtain a Primary Care Provider (PCP). Your health plan might require you to have a PCP in order for certain services to be covered. MIT Medical is available to help you select a PCP if you would like our assistance. But it is your responsibility to obtain a PCP when one is required, and confirm that your health plan has your PCP on file before you receive any services.

MIT Medical will make every effort to bill your health insurance company and/or CMS for any services provided, but we cannot guarantee that your insurance company and/or CMS will pay any or all of the charges, and you may be responsible for the charges not paid by your insurance company and/or CMS. Any unpaid balances are your responsibility. MIT Medical is available to discuss any outstanding balances, as needed, and, if appropriate, work with you on a repayment plan.

By signing this document, you are authorizing MIT Medical to release medical or other information necessary to insurance carriers and/or CMS to process any insurance claims. You are also authorizing MIT Medical to receive payment for any services for you or your covered dependents related to those claims from your insurance company and/or CMS.

MIT Medical will, upon your request, provide an estimate of the cost of anticipated medical services that may be provided at MIT Medical, including the CPT codes for all anticipated services and procedures, to help you identify the costs associated with the services before they are rendered.

Copayments

Payment of any co-payments is expected at time of service on each date of service when required by your insurance or CMS. Please note that copayments may be required when problems, including, but not limited to hypertension, diabetes, high cholesterol or depression, are addressed during an annual physical or wellness visit.

Workers’ Compensation and Motor Vehicle Accident Visits

If your visit is the result of a work-related injury or a motor vehicle accident, you must notify MIT Medical prior to receiving any services and provide us with the information and/or forms for your auto insurer, workers’ compensation carrier or employer so that we can direct the claim for your services to the appropriate party. In the event that the worker’s compensation or auto insurance carrier does not pay for any services provided, MIT Medical will submit these claims to your health insurance company and/or CMS.

Billing

MIT Medical may bill you for any co-payments, coinsurance, deductibles, out-of-network charges or non-covered services, as determined by your insurance coverage or CMS. Please pay the charges indicated on your statement in full by the date indicated.

Please understand we reserve the right to transfer delinquent accounts to a collection agency after all efforts have been exhausted to obtain payment from you. We realize that special circumstances may occur and MIT Medical will work to assist you to resolve any outstanding balances, as needed.

Questions

If you have any questions or concerns regarding a bill you have received from MIT Medical, please contact the Billing Department by email at billing@med.mit.edu or phone at 617-258-5336 (Monday – Friday 8:30 a.m. to 3:00 p.m.).

Acknowledgment (required)

I acknowledge receipt of these financial responsibility guidelines.

patient, parent/guardian, or responsible party signature __________________________ date (month/day/year) ____________

printed name __________________________