# IMMUNIZATION AND MEDICAL HISTORY RECORD

## PART A: STUDENT INFORMATION

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<tr>
<th>Date of Birth</th>
<th>Student ID</th>
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According to Massachusetts law 105 CMR 220.600, all full-time students (12 or more credits) and all full-time and part-time students in Health Profession programs must present evidence of immunization against measles, mumps, rubella; tetanus, diphtheria and pertussis; varicella (chickenpox), Hepatitis B, and Meningitis (if 21 years and under), to attend classes.

If you are exempt from the Massachusetts law 105 CMR 220.600, please check the below reason, sign your name and date below, and complete PART C (Medical History).

- [ ] I am a part-time student not enrolled in a Health Profession Program.
- [ ] Such immunizations conflict with my religious beliefs (see M.G.L. c. 76s.15C).
- [ ] I am submitting a physician's statement, which verifies that my physical condition will be endangered by the required immunizations.

(Complete PART B – page 1)

If you are NOT exempt from the Massachusetts law 105 CMR 220.600, please complete PART C and have your health care provider, (MD,NP, PA) complete PART B.

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<th>Student’s signature</th>
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## PART B: IMMUNIZATION VERIFICATION (To be completed by a health care provider)

### IMMUNIZATIONS

#### TETANUS-DIPHTHERIA-PERTUSSIS

- **DATE(s):** MONTH/DAY/YEAR

- **Tdap (1 dose required)**
  - [ ] __/__/____

#### MMR:

- **(or positive titers for Measles, Mumps, Rubella)**
  - Measles (2 doses required)
    - [ ] __/__/____
  - Mumps (2 doses required)
    - [ ] __/__/____
  - Rubella (2 doses required)
    - [ ] __/__/____

#### VARICELLA:

- **(Vaccine or antibody titer required for Health Profession Students and International Students)**
  - 1. History of Varicella (chickenpox) [ ] Yes [ ] No
  - 2. Varicella vaccine
    - [ ] __/__/____
  - 3. Varicella titer results
    - [ ] __/__/____
    - [ ] Pos [ ] Neg

#### HEPATITIS B:

- **(3 doses required or titer results)**
  - Titer results
    - [ ] __/__/____
    - [ ] Pos [ ] Neg

- [ ] __/__/____
- [ ] __/__/____
- [ ] __/__/____

#### MENINGOCOCCAL:

- 1 dose of MCV4 if 21 years and under – or a signed waiver
  - [ ] __/__/____

#### TUBERCULOSIS TEST:

- **(Required for Health Profession Students and International Students)**
  - **TB test results - within past 6 months.**
    - [ ] __/__/____
  - **Submit official chest x-ray report if PPD is positive.**
    - [ ] __/__/____

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This information is for the use of the College and will not be released without the student’s written consent.

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**Contact Person In Case of Emergency**

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<th>Last Name</th>
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<th>Relationship</th>
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<tr>
<th>Home Phone Number</th>
<th>Work Phone Number</th>
<th>Cell Phone Number</th>
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Do you have any health problems we should be aware of? If yes, please comment:
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________
________________________________________________________________________________________________________________________________________

- [ ] Current medications
- [ ] Hospitalizations
- [ ] Allergies (medication, food, pets, etc.)
- [ ] Special accommodations required
- [ ] High blood pressure
- [ ] Diabetes
- [ ] Other

**Comments**

Please return this form to:
Roxbury Community College
**Enrollment Center**
Academic Building (3), Room 219
1234 Columbus Avenue
Roxbury Crossing, MA 02120

This form must be returned within 30 days of registration.