



Roxbury Community College

Admissions Office
 1234 Columbus Avenue
 Roxbury Crossing, MA 02120
 Tel. (617) 427-0060 Ext. 5030

PART A: Student Information

<hr/> <i>Last Name</i>	<hr/> <i>First Name</i>	<hr/> <i>MI</i>
<hr/> <i>Date of Birth</i>	<hr/> <i>Social Security No.</i>	
<hr/> <i>Street Address</i>	<hr/> <i>City</i>	<hr/> <i>State</i>
		<hr/> <i>Zip Code</i>

According to the Massachusetts law 105 CMR 220.600, all full-time students (12 or more credits) including full-time students in Health Career programs must present evidence of immunization against Measles, Mumps, Rubella, Tetanus, and Hepatitis B in order to attend classes.

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

- I am a part-time student not enrolled in a Health Career 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)**

If you are **NOT** exempt from the Massachusetts law 105 CMR 220.600, please check the appropriate box below, complete PART C and have your physician complete PART B.

- I am submitting a copy of my school Immunization Record
- I am submitting an immunization history signed by a physician, verifying my immunizations. (Complete Part B below)

<hr/> <i>Student's signature</i>	<hr/> <i>Date</i>
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PART B: Immunization Verification (To be completed by Physician)

Immunization	# of dose	Date
DTP/Td/DT (a booster is required if the last dose was over ten years ago)	<hr/>	<hr/>
Measles (2 doses required)	<hr/>	<hr/>
Mumps	<hr/>	<hr/>
Rubella	<hr/>	<hr/>
Hepatitis B	<hr/>	<hr/>
Tuberculosis Test (International Students only)	<hr/>	<hr/>
PPD (Mantoux) test within 6 months	<hr/>	<hr/>
Chest X-Ray required if PPD is positive	<hr/>	<hr/>

<hr/> <i>Physician's Signature</i>	<hr/> <i>Print Name</i>	<hr/> <i>Date</i>
<hr/> <i>Street Address</i>	<hr/> <i>City</i>	<hr/> <i>State</i>
		<hr/> <i>Zip Code</i>

PART C: Medical History

This information is for the use of the college and will not be released without student's written consent

Contact Person In Case of Emergency

First Name

Last Name

Relationship

Home Number

Work Number

Cell Number

Street Address

City

State

Zip Code

Please check below the box(es) applicable to you, if any:

Comments

- Under Medication
- Special Diet
- Allergies (medication, food, pets, etc.)
- Disabled
- Heart trouble
- Diabetes
- Seizures
- High Blood Pressure
- Kidney problems
- Low Blood (Anemia)
- Alcohol/drug issues
- Lung Disease
- Other

Please check below the topic(s) you would like Student Health Services to offer as part of it's health education program:

- Diabetes
- Weight Control
- Single Parenting
- Family Planning
- Domestic Violence
- High Blood Pressure
- Personal Relationships
- Alcohols/Drug Education

Please return this form to:

**Roxbury Community College
Admissions Office./Administration Bldg., Rm. 101
Roxbury Crossing, MA 02120 - 3400
Tel. (617) 541-5310**