Wellness Center
Health Sciences Building #4, Room 313
1234 Columbus Avenue,
Roxbury Crossing, MA 02120
Email: studentimmunization@rcc.mass.edu

IMMUNIZATION AND HEALTH INFORMATION FORM

PART A: STUDENT INFORMATION

Last Name _____ First Name _____ MI _____

Date of Birth _____ Student ID _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip Code _____

According to Massachusetts law 105 CMR 220.600, all full-time students (12 or more credits) under the age of 30 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 (Health Information Form).

- ☐ I am a part-time student OR not enrolled in a Health Profession Program OR over 30 years of age.
- ☐ 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.

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.

Student's signature _____ Date ____/____/_____

PART B: IMMUNIZATION VERIFICATION (To be completed by a health care provider)

IMMUNIZATIONS **DATE(S):** MONTH/DAY/YEAR

Tetanus-Diptheria-Pertussis: Tdap (1 dose required) then a Td booster every 10 years ____/____/_____

MMR: (2 doses or positive titers for Measles, Mumps, Rubella) #1____/____/_____ #2 ____/____/_____

Varicella: (Vaccine or antibody titer required for Health Profession Students and International Students)

1. History of Varicella (chickenpox) ☐ Yes ☐ No (exempt if born in the United States before 1980)
2. Varicella vaccine #1____/____/_____ #2 ____/____/_____
3. Varicella titer results Date:____/____/_____ ☐ Pos ☐ Neg

Hepatitis B: (3 doses required or titer results) #1____/____/_____ #2 ____/____/_____ #3 ____/____/_____
Titer results Date:____/____/_____ ☐ Pos ☐ Neg

Meningococcal: 1 dose of MenACWY 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. Date: ____/____/_____ Results: _____ #MM_____

Submit official chest x-ray report if PPD is positive. Date: ____/____/_____ Results: _____

Signature _____ Printed Name _____ Date ____/____/_____

Street Address _____ City _____ State _____ Zip Code _____

Telephone number _____ NPI# _____

PART C: HEALTH INFORMATION FORM

To be completed by the student – please print

Last Name _____ First Name _____ MI _____

Date of Birth _____ Student ID _____ Telephone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Contact Person In Case of Emergency

Last Name _____ First Name _____ Relationship _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

If you have any questions about the Massachusetts immunization requirements, please contact:

Wellness Center
Kara Lopez, RN-MSN, PMHNP-BC
Health Sciences Building (4), Room 313
Email: studentimmunization@rcc.mass.edu
Fax: 833-392-7712

For accommodation requests or to connect with Accessibility Services, please contact:

Student Accessibility Services
Academic Building (3), Room 201A
Tel: 857-701-1278
Email: accessibility@rcc.mass.edu

This form must be returned within 30 days of registration to:

Wellness Center
Kara Lopez, RN-MSN, PMHNP-BC
Health Sciences Building (4), Room 313
Email: studentimmunization@rcc.mass.edu
Fax: 833-392-7712

Medical and Religious Exeptions must be resubmitted at the start of each school year

This form must be returned within 30 days of registration.