

Immunization and Medical History Record

Part A Student Information

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
Street Address	City	State Zip Code Phone Number

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 (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.

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

Student's signature	Date
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Part B: Immunization Verification (to be completed by a health care provider)

IMMUNIZATIONS:	DATE(S): MONTH/DAY/YEAR
Tetanus-Diphtheria-Pertussis: Tdap (1 dose required) then a Td booster every 10 years	___/___/___
MMR: (2 doses or positive titers for Measles, Mumps, Rubella)	
Measles (2 doses required)	#1 ___/___/___ #2 ___/___/___
Mumps (2 doses required)	#1 ___/___/___ #2 ___/___/___
Rubella (2 doses required)	#1 ___/___/___ #2 ___/___/___
Varicella: (Vaccine or antibody titer required for Health Profession Students and International Students)	
1. History of Varicella (chickenpox) <input type="checkbox"/> Yes <input type="checkbox"/> No (exempt if born in the United States before 1980)	
2. Varicella vaccine	#1 ___/___/___ #2 ___/___/___
3. Varicella titer results	Date: ___/___/___ <input type="checkbox"/> Pos <input type="checkbox"/> Neg
Hepatitis B: (3 doses required or titer results)	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Titer results	Date: ___/___/___ <input type="checkbox"/> Pos <input type="checkbox"/> 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)	
<i>TB test results - within past 6 months.</i>	Date: ___/___/___ Results: _____ # mm _____
<i>Submit official chest x-ray report if PPD is positive.</i>	Date: ___/___/___ Results: _____

Signature	Printed Name	Date
Street Address	City	State Zip Code Phone Number

If you have a health condition that you would like the College Nurse to know about, please contact:

Student Health Services

Health Sciences Building (4), Room 313

Tel: 857-701-1657

Email: rhines@rcc.mass.edu

If you have a disability that you would like the Accessibilities Director to know about, please contact:

Student Accessibilities

Academic Building (3), Room 201A

Tel: 857-701-1410

Email: jcrary@rcc.mass.edu