ROXBURY COMMUNITY COLLEGE

Enrollment Center
(Temporary location) Academic Building, Room 3-219
1234 Columbus Avenue, Roxbury Crossing, MA 02120
Tel. 857-701-1200 | Fax 855-670-1795
Email: Enrollment.Management@rcc.mass.edu

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 ______

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.

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) ____/____/______

MMR: (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) ☐ Yes ☐ No
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 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. Date: ____/____/______ Results: ____________________

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

Signature ____________________ Printed Name ____________________ Date ____/____/______

Street Address ____________________ City ____________________ State ______ Zip Code ______

Telephone number ____________________

PART C: MEDICAL HISTORY

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

Last Name ______ First Name ______ MI ______

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 ______

Do you have any health problems we should be aware of? If yes, please comment: ______

	Comments
☐ Current medications	______
☐ Hospitalizations	______
☐ Allergies (medication, food, pets, etc.)	______
☐ Special accommodations required	______
☐ High blood pressure	______
☐ Diabetes	______
☐ Other	______

Please return this form to:

Roxbury Community College
Enrollment Center
Administration Building (2), Room 102
1234 Columbus Avenue
Roxbury Crossing, MA 02120

This form must be returned within 30 days of registration.