PHYSICAL AND IMMUNIZATION FORM

Mount Wachusett Community College
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c/o Katherine Kusza, RN

Massachusetts General Law 105 CMR 220.600 requires ALL FULL-TIME STUDENTS (12 CREDITS OR MORE) to provide the following record of immunizations. Health Science/International students require additional immunizations. Completed forms are necessary to demonstrate compliance with the law.

Last Name **First Name** **Middle** **Student ID #**

Street Address **City** **State** **Zip Code**

Home Phone **Cell Phone** **Emergency Contact/Next of Kin Name/Phone Number**

REQUIRED IMMUNIZATIONS: (Full-time students, all Health Science Students and all International Students)

MMR: **#1**_____ **#2**_____ **or Positive Titer (Please attach lab results)**

Varicella: **#1**_____ **#2**_____ **or Positive Titer (Please attach lab results)**

Hepatitis B: **#1**_____ **#2**_____ **#3**_____ **or Positive Titer* (Please attach lab results)**
***(positive Hep B Titer showing immunity also required of all Health Science Students)**

TDAP: **#1**_____ **(within 10 years)**

Meningococcal: **#1**_____ **(students ages 16-21)**

Influenza: **#1**_____ **(annually)**

2 step PPD (Date/Result) **: **#1**_____ **#2**_____ **or TB Spot/Quantiferon Gold (Date/Result)** **#1**_____
** (Annually for Health Science and International Students)**

REPORT OF HEALTH EVALUATION: (All Health Science and International Students)

Are there any abnormalities of the following systems? Describe fully. Include Pertinent Medical History.

BP_____**HR**_____**RR**_____

	Yes	No
Head, Ears, Nose or Throat		
Respiratory		
Cardiovascular		
Gastrointestinal		
Hernia		
Eyes		
Genitourinary		
Musculoskeletal		
Metabolic/Endocrine		
Neuropsychiatric		
Skin		

Is there loss or seriously impaired function of any organ? Yes ❑ No ❑
Have you any general comments?
Is the Student physically able to participate in all physical activities, sports and Fitness and Wellness?

Unlimited ❑ **Limited ❑** **Explain:** **Date of most recent Physical** _____

Physician's Signature _____ Date _____

Physician's Printed Name_____

Physician's Address _____

City _____ State _____ Zip Code _____ Phone _____