# mwccgardaddressb&w

**FAX # 978-630-9528**

c/o Katherine Kusza, RN

# PHYSICAL AND IMMUNIZATION FORM

**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 is required of all Health Science Students)**

**TDAP: #1\_\_\_\_\_\_\_\_ (within 10 years)**

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

**Influenza: #1\_\_\_\_\_\_\_\_ (annually Health Science Students)**

**Tuberculosis Testing (Annually for Health Science and International Students)**

**TB Spot/Quantiferon Gold (Date/Result) #1\_\_\_\_\_\_\_\_ or 2 step PPD (Date/Result 2 weeks apart): #1\_\_\_\_\_\_\_\_#2\_\_\_\_\_\_\_\_**

# REPORT OF HEALTH EVALUATION: (All Health Science and International Students every two years)

**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_