



444 Green Street, Gardner, MA 01440-1000

FAX # (978) 630-9528
c/o Diane King, RN, BSN, HNC

TO: All Full-Time Students (12 credits or more during a semester including students in Cycle courses); All Students on a Student Visa, including foreign students attending or visiting classes as part of a formal academic visitation exchange program; All Full and Part-Time Allied Health Students—Clinical Lab Science, Complementary Health Care Certificate/Degree, Dental Hygiene, Medical Assisting, Massage Therapy Certificate, Nursing, Phlebotomy, and Physical Therapist Assistant

FROM: Ann S. McDonald
Vice President of Student Services and Enrollment Management

SUBJECT: REQUIREMENTS FOR IMMUNIZATION AND MEDICAL HISTORY

The Laws of the Commonwealth of Massachusetts mandate that the College require certain medical documentation prior to class attendance. Failure to comply may result in: Suspension from classes this semester, prevention from enrolling in subsequent semesters, and withholding of grades and diploma. Therefore, we ask your cooperation in adhering to the following policies as they pertain to you.

In order to complete your records, Health Services requires the following documentation before classes begin:

- Measles immunization #1
- Measles immunization #2 or proof of immunity
- Rubella immunization or proof of immunity
- Mumps immunization or proof of immunity
- Diphtheria-Tetanus booster (within 10 years)
- Hepatitis B vaccine (3 doses) or proof of immunity
- Meningococcal vaccine is required for all students at a postsecondary school that provide or license housing. (Fitchburg Institute students)

Required for: All Full and Part-time Allied Health Students and Phlebotomy students
Annual;
& EVERY STUDENT on a STUDENT VISA
including all foreign students;
 • Intra-dermal Tuberculin Test

Physical Exam Form

All full-time students enrolled in a degree program, and Allied Health students, must complete side one and have their physician complete, sign and date side two of the enclosed physical form.

Health Records may be obtained from the following sources

- | | |
|-----------------------------|---------------------|
| 1. Your physician | 3. Your baby book |
| 2. Your high school records | 4. Military records |

If the above immunizations cannot be found the following may provide re-immunization

1. Your physician
2. Walk-in health center
3. Your local board of health

Please take prompt action to return the enclosed signed forms to:

MWCC Health Services, 444 Green Street, Gardner, MA 01440
or Fax to (978) 630-9528 c/o Diane King, RN, BSN, HNC
Prior to the first day of classes

If you have questions or concerns, please contact the Health Services office at (978) 630-9136.

REPORT OF HEALTH EVALUATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physician's form. Please comment on all positive answers. **THIS STUDENT HAS BEEN ACCEPTED.** The information supplied will not affect his/her status; it will be used only as a background for providing health care, if this is necessary. This information is strictly for the use of Health Services and will not be released without student consent.

Last Name _____		First Name _____		Middle _____	Student ID # or SS _____
BP _____ / _____	Color Blindness _____		Height _____ inches	Weight _____ lbs	
Vision _____	Corrected Vision _____		Overweight _____	Underweight _____	
Right 20/ _____	Left 20/ _____	Right 20/ _____	Left 20/ _____	Normal Weight _____	
Urinalysis: Sugar _____ Albumin _____				Micro. _____	Hemoglobin (if indicated) _____ Grm/%

IMMUNIZATIONS – ALL IMMUNIZATIONS ARE REQUIRED - (105 CMR 220.600)
 for all full time students, Any full- or part-time student attending an institution of higher education while on a student or other visa, including foreign students attending or visiting classes as part of a formal academic visitation exchange program;, and all students enrolled in a Allied Health program.

Diphtheria, Tetanus (within 10 years) TDAP		Date _____			
Measles (after 12 months of age) Mumps & Rubella		MMR #1		MMR #2	
Hepatitis B Vaccine (3 Doses)	#1	#2	#3		
Required for all Allied Health Students annually, Every Student on a Student Visa or Other Visa. TB Skin Test Date: _____ Results: _____					

Are there any abnormalities of the following systems? Describe fully. Use additional sheet if necessary.

	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 Number _____

REPORT OF MEDICAL HISTORY

Please return to: Health Services Office
Telephone: 978-630-9136
Fax: 978-630-9528 c/o Diane King, R.N. BSN

This information is strictly for the use of the Health Services Office and will not be released to anyone without your knowledge and consent.

Last Name (print)	First Name	Middle (Maiden Name)	
Home Address (Number and Street)	City or Town	State	Zip code
Your Home Telephone Number	Date of Birth		
Next of Kin (Name, Relationship, and Address)			Home Telephone Number
Next of Kin's Business Address			Business Telephone
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		Your Age: _____	Citizenship _____

Family History - Complete on back if necessary.

	Age	State of Health	Occupation	Age at Death	Cause of Death
Father					
Mother					
Husband, Wife or Children					
Brothers					
Sisters					

Have any of your relatives ever had any of the following:

	Yes	No	Relationship
Tuberculosis			
Diabetes			
Kidney Disease			
Heart Disease			
Arthritis			
Stomach Disease			
Asthma, Hay Fever			
Epilepsy, Convulsions			

Personal History: Please answer all questions. Comment on all positive answers on the back of this sheet.

Have you had:	Yes	No	Yes	No	Yes	No	Yes	No
Scarlet Fever			Insomnia		Pain/Pressure in Chest		Heart Disease	
Measles			Frequent Anxiety		Chronic cough		Galbladder Trouble or Gallstones	
German Measles			Frequent Depression		Palpitations		Recurrent Diarrhea	
Mumps			Worry or Nervousness		High or Low Blood Pressure		Rupture, Hernia	
Chicken Pox			Recurrent Headaches		Rheumatic Fever or Heart Murmur		Recent Gain or Loss of Weight	
Malaria			Recurrent Colds		Disease or Injury of Joints		Dizziness, Fainting	
Gum or Tooth Trouble			Head Injury with Unconsciousness		"Trick" Knee Shoulders, etc.		Weakness, Paralysis	
Sinusitis			Hay Fever, Asthma		Back Problems		Veneral Disease	
Eye Trouble			Tuberculosis		Tumor, Cancer, Cyst		Albumin/Sugar in Urine	
Ear, Nose, Throat Trouble			Shortness of Breath		Jaundice		Kidney Disease	
Surgery			Allergy		Stomach or Intestinal Trouble		Females Only:	
Appendectomy			Penicillin		Epilepsy, Convulsions		Irregular Periods	
Tonsillectomy			Sulfonamides				Severe Cramps	
Hernia Repair			Serum				Excessive Flow	
Other (specify)			Foods (which)					
Diabetes			Other (specify)					
			Arthritis					

Please comment on all positive answers on the bottom of sheet

A. Has your physical activity been restricted during the past five years? yes no

B. Do you have any questions in regard to your health, family history, or other matters, which you would like to discuss now with a member of the staff of health services? yes no If yes, please make an appointment with a member of the Health Services staff by calling 978-630-9136.

Student's Signature: _____

Physician's Signature: _____

Date: _____