



Health Record

Student ID #: **A00** _____ (office use only)

A Certificate of Health, completed Immunization Record, and Tuberculosis Test results must be submitted to the College International Student Office as part of the application process for a student visa and for the student to enroll in classes. This form is confidential and will be kept on file at the College.

Last Name _____ First Name _____ MI: _____ Gender: Male Female

Permanent Foreign Address: _____

Local Mailing Address: _____

City _____ State _____ Zip Code _____

Telephone Number (_____) _____ Area Code Academic Major _____ Date of Birth: _____ month/day/year

In case of Emergency notify:

Name _____ Telephone Number (_____) _____ Area Code

Physician's Name _____ Telephone Number (_____) _____ Area Code

Name of Medical Insurance Plan for Fall and Spring Semesters _____

PHYSICIAN'S CERTIFICATE OF HEALTH

The above named patient has been examined by me on this date and found to be free of any acute or chronic disease and is able to engage in all activities without restriction except as noted here: _____

Name of Physician _____ Date _____

Physician Signature _____

Address _____

If the student has any disabilities, which may need accommodations, it is the student's responsibility to apply for services at Middlesex Community College, Disability Support Services.

TB/PPD/MANTOUX TEST (required regardless of previous BCG vaccine)

Date Implanted _____ Date Read _____ Result: Negative _____ Positive * _____

OR T-Spot or Quantiferon (Blood Tests) Date: _____ (Attach Laboratory Report)

*A chest x-ray report done within the last three months is required for a positive reactor.

REQUIRED IMMUNIZATIONS

Documentation required by Massachusetts Law. **NOTE:** Immune titers for Measles, Mumps, Rubella, Hepatitis B, and Varicella may be substituted for vaccine. Please provide copy of laboratory reports.

	Month / Day / Year
Tdap (one lifetime dose after 2006)	
Td (if Tdap greater than 10 years)	
Measles/Mumps/Rubella (MMR #1)	
Measles/Mumps/Rubella (MMR #2)	
Varicella (history of the disease) OR	
Varicella vaccine (#1)	
Varicella vaccine (#2)	

	Month / Day / Year
Hepatitis B (#1)	
Hepatitis B (#2)	
Hepatitis B (#3)	
Meningococcal (MenACWY) (full-time students 21 years of age or younger received on or after 16th birthday)	
Covid-19 (#1)	
Covid-19 (#2)	