



Mail completed form to:

Worcester State College
Student Health Services
486 Chandler Street, Worcester, MA 01602

Phone: 508-929-8875
Fax: 508-929-8075

Please check all appropriate boxes:

Commuter Campus resident Freshman Graduate Transfer
Returning (years attended: ) Nursing, OT, CD Status: PT FT

This Health Examination Form must be completed in its entirety. Incomplete reports will be returned.

Name Last First Middle

Social Security #

Birthdate Month Day Year Birthplace

Male Female Married Single Other

Permanent Home Address: No. Street

City State Zip

Home Phone ( ) Student's Cell# ( )

Father's Name Last First Middle Mother's Name Last First Middle

Home Address No. Street Home Address No. Street

City State Zip City State Zip

Home Phone ( ) Home Phone ( )

Business Phone ( ) Business Phone ( )

Someone other than parents to be notified in case of emergency (if parents are unavailable):

Name Phone Number ( )

Address

Do you have any allergy to medication? Yes No

Please list:

Do you have any serious medical condition? Yes No

If yes, please explain:

FOR OFFICE USE ONLY

College Address

College Telephone #

**IMMUNIZATION RECORD  
WORCESTER STATE COLLEGE  
STUDENT HEALTH SERVICES**

**Part I**

Name \_\_\_\_\_  
Last Name
First Name

Date of Birth \_\_\_\_\_  
Month / Day / Year

**Part II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.**

**REQUIRED VACCINES:**

**A. TETANUS-DIPHTHERIA**

1. Tetanus-Diphtheria booster must be within the last ten years ..... \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**B. M.M.R. (Measles, Mumps, Rubella) (two doses required or individual vaccine as noted below)**

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980 ..... 1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr 2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**OR Measles, Mumps, Rubella Titers**

**MEASLES (Rubeola) (check all that apply)**

1. Has report of positive immune titer. Specify date..... \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**RUBELLA (German Measles) (clinical history is not acceptable) (check all that apply)**

1. Has report of positive immune titer. Specify date..... \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**MUMPS (check all that apply)**

1. Has report of positive immune titer. Specify date..... \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**C. HEPATITIS B (Three doses of vaccine or a positive Hepatitis B surface antibody meets the requirement.)**

1. Dose #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr Dose #3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

2. Hepatitis B surface antibody \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

**FULL-TIME RESIDENT STUDENTS ONLY:**

**D. MENINGOCOCCAL (One dose required within 5 years of entry into college or the enclosed waiver may be signed stating that the student has received information regarding meningococcal disease/vaccination and wishes to decline immunization.)**

Vaccinated ..... Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr Type of Vaccine: Menommune \_\_\_\_\_  
Menactra \_\_\_\_\_

**RECOMMENDED VACCINES:**

**E. VARICELLA**

Rx of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ Vaccinated \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo Day Yr

**I. TUBERCULOSIS SCREENING<sup>1</sup> (PLEASE COMPLETE QUESTIONS 1 AND 2)**

1. Does the student have signs or symptoms of active tuberculosis disease? Yes \_\_\_\_\_ No \_\_\_\_\_ **If No, proceed to 2.**  
If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
2. Is the student a member of a high-risk group or is the student entering the health professions?<sup>2</sup> Yes \_\_\_\_\_ No \_\_\_\_\_  
If **NO**, stop. If **YES**, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm). A history of BCG vaccination should not preclude testing of a member of a high-risk group.
3. Tuberculin Skin Test:  
Date Given: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Read: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Yr Mo Day Yr  
Result: \_\_\_\_\_ (Record actual mm of induration, transverse diameter; if no induration, write "0")  
Interpretation (based on mm of induration as well as risk factors): positive \_\_\_\_\_ negative \_\_\_\_\_
4. Chest x-ray (require if tuberculin skin test is positive) result: normal \_\_\_\_\_ abnormal \_\_\_\_\_  
Date of chest x-ray: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Mo Day Yr

**HEALTH CARE PROVIDER**

Name \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Phone \_\_\_\_\_

<sup>1</sup> The American College Health Association has published guidelines on tuberculosis screening of college and university students. These guidelines are based on recommendations from the Centers for Disease Control and the American Thoracic Society. For more information, visit [www.acha.org](http://www.acha.org) or refer to the CDC's Core Curriculum on Tuberculosis available at state health departments or at the following web site: [www.cdc.gov/nchstp/tb/pubs/corecurr/](http://www.cdc.gov/nchstp/tb/pubs/corecurr/).

<sup>2</sup> Categories of high risk students include those students who have arrived within the past 5 years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from countries EXCEPT those on the following list: Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia, or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone  $\geq$  15mg/d for  $\geq$  1 month) or other immunosuppressive disorders.

*Prepared by ACHA's Vaccine-Preventable Diseases Task Force*

**HEALTH INSURANCE**

Massachusetts Student Plan \_\_\_\_\_ Yes \_\_\_\_\_ No

Health Insurance Provider, if not Massachusetts State System Plan: **PLEASE ATTACH COPY OF HEALTH INSURANCE CARD**

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**MEDICAL TREATMENT RELEASE FOR STUDENTS UNDER 18 YEARS**

**PARENTAL PERMISSION**

In the event that medical treatment is found to be necessary, I hereby authorize a physician or such assistants as may be selected by him to render medical treatment to my son/daughter.

If in treatment of a condition, in the exercise of professional judgment, hospitalization is deemed necessary, I hereby consent to hospital care encompassing routine diagnostic procedure, medical treatment, and surgery which may involve the administration of anesthesia.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian's Signature

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## MEDICAL HISTORY

**PLEASE COMPLETE THIS FORM BEFORE GOING TO YOUR PHYSICIAN FOR EXAMINATION.**

Have you ever had or have you now a problem with (check at right of each item): (*Explain YES answers below*)

Check each item:	Yes	No	Yes	No	Yes	No			
Head & nervous system			Poor teeth/toothaches		Hepatitis or jaundice		Exposure to DES		
Headaches			Gum Disease		Genitourinary system		Infectious disease		
Fainting			Heart, Lungs		Blood in urine		Mononucleosis		
Severe head injury			High blood pressure		Cystitis		Chicken pox		
Seizures/convulsions			Heart murmur		Kidney infection/disease		TB or positive skin test		
Dizzy spells			Heart trouble		Menstrual disorder		Past illnesses		
Insomnia			Palpitations		Bones, joints		Operations		
Eyes			Shortness of breath		Fractures/dislocations		Serious injuries		
Blindness			Chronic cough		Knee problems		Serious illness		
Double vision			Pneumonia		Deformity		Substance abuse		
Deafness, hearing aid			Asthma		Arthritis		Psychological illness		
Perforated eardrum			Bronchitis		Back problems		Medication allergy —		
Frequent ear infections			Digestive system		Tumor or growth		please list:		
Frequent nose bleeds			Abdominal pain		Skin disorder				
Frequent sore throats			Diarrhea; chronic/recurrent		Diabetes				
Neck			Colitis, ileitis		High cholesterol		Other Allergies:		
Frequent swollen glands			Irritable bowel		Eating disorder				
Thyroid dysfunction			Gall stones		Sickle cell trait/disease				

Explanation of YES answers: \_\_\_\_\_

**TO THE HEALTH CARE PROVIDER:** Please review the student's history and complete the physician's form. The information supplied will be used as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without student consent.

Name: \_\_\_\_\_  
Last First Middle

Height: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Vision \_\_\_\_\_

Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Rt. \_\_\_\_\_ Lt. \_\_\_\_\_ \*Glasses: Rt. \_\_\_\_\_ Lt. \_\_\_\_\_

	System	Normal	Abnormal		System	Normal	Abnormal
1	Skin			11	Hernia		
2	Ears			12	Genitalia		
3	Eyes			13	Pelvic (if indicated)		
4	Nose, throat, teeth			14	Rectal		
5	Neck, thyroid			15	Lymphatic		
6	Chest, breasts			16	Extremities		
7	Lungs			17	Neurological		
8	Heart			18	Psychological		
9	Heart murmur			19	Back & spine		
10	Abdomen, liver spleen, kidneys			20	Joints, shoulders, knees & ankles		

Results of Urinalysis: \_\_\_\_\_

List any current illness(es), medications and explanations of abnormal findings: \_\_\_\_\_

Capable of participating in sports? Yes \_\_\_\_\_ No \_\_\_\_\_ Collision \_\_\_\_\_ Contact \_\_\_\_\_ Non-Contact \_\_\_\_\_

Signature of Health Care Provider: \_\_\_\_\_

Printed Name of Health Care Provider \_\_\_\_\_ Date of Examination \_\_\_\_\_