



Dear Newly Accepted Graduate Student:

The Department of Public Health insists that all colleges and universities in the State fully comply with the College Immunization Law. The law states that “all full-time college students, as well as part-time students in health science must present evidence that they are immunized against measles, mumps, rubella (MMR), diphtheria, and tetanus and the have completed the Hepatitis B Series in order to register for classes. The meningitis vaccine is also required for all newly enrolled full-time students who will be living in on-campus housing. Dates, including month, day and year of immunization, must be filed with Health Services. Students will not be allowed to register if immunization information is not provided to Student Health Services.

Each student is responsible for providing evidence of the following immunizations:

1. Measles, mumps, rubella (MMR) vaccine given after the age of one, or after Jan. 1 1968, and a second dose given at 18 month of age or after.
2. Any combination of three or more doses of DPT, DT or tetanus provided the last dose was administered within 10 years.
3. A complete series of three Hepatitis B immunizations.
4. Meningitis vaccine given within the last 5 years. (required for students living on-campus)

Only the following statements are acceptable in lieu of immunization histories:

1. A medical certificate signed by a physician stating specific immunizations are contraindicated for health reasons.
2. A statement signed by a clergyman indicating immunization conflicts with religious beliefs.
3. Laboratory evidence of immunity for measles, mumps, rubella and evidence for Hepatitis B.
4. **Only** the meningitis vaccine may be waived by completing the enclosed waiver form.

In addition, please complete the enclosed report of medical history and have a physical examination performed by a health care provider.

Please send all documentation directly to Ms. Nancy Quattrocchi, Director of Health Services, 30 days prior to registration.

Student Health Services  
University of Massachusetts Lowell  
71 Wilder Street, Suite 5  
Lowell, MA 01857-3091  
(978) 934-4991

# U MASS LOWELL STUDENT HEALTH SERVICES



71 Wilder St. Suite 5  
Lowell, MA 01854-3091

## HEALTH EXAMINATION REPORT

**STUDENTS WHO DO NOT SUBMIT A COMPLETE HEALTH EXAMINATION REPORT AND IMMUNIZATION FORM WILL NOT BE PERMITTED TO REGISTER**

With the exception of your Immunization Records, this information is strictly for the use of the Health Center and will not be released to anyone without your knowledge and written consent. Please complete the first **two** pages of this form prior to going to your health care provider for examination.

Date Form Completed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name _____ <small style="display: flex; justify-content: space-between; width: 90%; margin-left: 10%; margin-right: 10%;"> <span>Last</span> <span>First</span> <span>Middle</span> </small>	Student ID or Social Security Number  _____ / ____ / ____
Home Address _____ <small style="display: flex; justify-content: space-between; width: 90%; margin-left: 10%; margin-right: 10%;"> <span>Street</span> </small>	Birth Date (Mo. Day Yr.)  _____ / ____ / ____
_____ <small style="display: flex; justify-content: space-between; width: 90%; margin-left: 10%; margin-right: 10%;"> <span>City</span> <span>State</span> <span>Zip Code</span> </small>	Home Telephone Number  _____
Birth Place _____	Male <input type="checkbox"/> Female <input type="checkbox"/>

Date Entering UMass Lowell      Fall     Spring     \_\_\_\_\_ Year    Undergraduate     Graduate       Transfer

Father's Name \_\_\_\_\_  
(or Guardian)      
Last
First
Middle

Occupation  
(h) \_\_\_\_\_  
(w) \_\_\_\_\_

---

Street
City
State
Zip Code
Telephone Numbers

Mother's Name \_\_\_\_\_  
(or Guardian)      
Last
First
Middle

Occupation  
(h) \_\_\_\_\_  
(w) \_\_\_\_\_

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Street
City
State
Zip Code
Telephone Numbers

**PERSON TO NOTIFY IN CASE OF AN EMERGENCY**

Name \_\_\_\_\_  

Last
First
Middle

Occupation  
(h) \_\_\_\_\_  
(w) \_\_\_\_\_

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Street
City
State
Zip Code
Telephone Numbers

School Insurance    Yes     No

Other Insurance: \_\_\_\_\_ / \_\_\_\_\_  

Company
State
Subscriber
ID Number
Group Number



# IMMUNIZATION RECORD

This form must be completed and signed by a health care provider

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, U Mass Lowell requires verification of immunity for measles, mumps, rubella, tetanus, diphtheria and hepatitis B. Exact dates are required for all immunizations and/or serologic test results. If serology titers indicate lack of immunity, vaccines must be administered. History of disease is not acceptable documentation of immunity.

Massachusetts Law (MGL Ch. 76, s.15D) now requires new full and part-time undergraduate and graduate students in degree granting programs at post-secondary institutions that provide or license housing to receive meningococcal vaccine. All new students, living on campus, must provide documentation of having received this vaccine (within the last five years) at least two weeks prior to the beginning of classes.

Student's Name \_\_\_\_\_  
Last
First
M.I.
Date of Birth

## I. REQUIRED IMMUNIZATIONS

Month    Day    Year

### MMR (Measles, Mumps, Rubella)

Dose 1 Immunized on or after first birthday

Dose 1

Dose 2 Given at least one month after Dose 1

Dose 2

\_\_\_\_    \_\_\_\_    \_\_\_\_  
 \_\_\_\_    \_\_\_\_    \_\_\_\_

If unable to document MMR immunization dates, must provide:

### MEASLES (Rubeola)

Measles serology immune titer value \_\_\_\_\_

Interpretation: Immune    Not Immune

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_

### MUMPS

Mumps serology immune titer value \_\_\_\_\_

Interpretation: Immune    Not immune

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_

### RUBELLA

Rubella serology immune titer value \_\_\_\_\_

Interpretation: Immune    Not immune

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_

### TETANUS-DIPHTHERIA

Completed primary series of tetanus-diphtheria immunizations

Date:

Received tetanus-diphtheria booster within last 10 years

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_  
 \_\_\_\_    \_\_\_\_    \_\_\_\_

### HEPATITIS B

Completed series of Hepatitis B immunizations

Dose 1

Date:

Dose 2

Date:

Dose 3

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_  
 \_\_\_\_    \_\_\_\_    \_\_\_\_  
 \_\_\_\_    \_\_\_\_    \_\_\_\_

If unable to document Hepatitis B immunization dates, must provide:

Hepatitis B serology \_\_\_\_\_

Interpretation: Immune    Not immune

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_

### MENINGOCOCCAL VACCINE

Menactra            or            Menimune

Date:

\_\_\_\_    \_\_\_\_    \_\_\_\_

## II. OTHER IMMUNIZATIONS

		Month	Day	Year		Month	Day	Year		Month	Day	Year
Varicella Vaccine	Dose 1	_____ /	_____ /	_____	Dose 2	_____ /	_____ /	_____	or titer	_____	_____	_____

### HEALTH CARE PROVIDER (Please print)

Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_

# PHYSICAL EXAMINATION

(Must be completed within the past twelve months)

Student Name \_\_\_\_\_

Date of Exam \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP \_\_\_\_\_ Pulse \_\_\_\_\_

Hearing: Right \_\_\_\_\_ Left \_\_\_\_\_

Vision: Without correction: Right 20/\_\_\_\_ Left 20/\_\_\_\_

With correction: Right 20/\_\_\_\_ Left 20/\_\_\_\_

The Athletic Trainer may have access to the physical examination report of students who elect to participate in athletics.

SYSTEM	NORMAL	DESCRIBE ABNORMALITY
Skin		
HEENT		
Respiratory		
Breasts		
Cardiovascular		
Gastrointestinal		
Genitourinary		
Pelvic (if indicated)		
Lymphatic		
Musculoskeletal		
Neurological		
Endocrine		
Psychological		

Lab Work (if indicated): Hgb/Hct: \_\_\_\_\_ Cholesterol: \_\_\_\_\_ Urine: Glucose: \_\_\_\_\_ Protein: \_\_\_\_\_ Micro: \_\_\_\_\_

## CURRENT MAJOR & CHRONIC PROBLEMS

## ACUTE & MINOR PROBLEMS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If the student is under care for a chronic condition or serious illness please provide additional clinical reports to assist us in providing continuity of care.

Additional comments and recommendations: \_\_\_\_\_  
\_\_\_\_\_

Please list any special **DIETARY REQUIREMENTS**: \_\_\_\_\_

Please list all **ALLERGIES** (including medications, insect venom, foods, etc.): \_\_\_\_\_

Type of reaction \_\_\_\_\_

Please list all **MEDICATIONS** currently being taken (include OTC's, contraceptives): \_\_\_\_\_  
\_\_\_\_\_

Recommendations for physical activity:  unlimited  limited (specify) \_\_\_\_\_

Health Care Provider (please print) \_\_\_\_\_

Address \_\_\_\_\_

Phone ( \_\_\_ ) \_\_\_\_\_ Fax ( \_\_\_ ) \_\_\_\_\_

Provider's Signature \_\_\_\_\_

Mail completed form to:  
UMASS Lowell  
Student Health Services  
71 Wilder Street, Suite 5  
Lowell, MA 01854-3091  
Telephone: (978)934-4991  
Fax: (978)934-3080