

# GRADUATE STUDENTS

## INFORMATION REGARDING IMMUNIZATION RECORD

You will not be allowed to register for classes until you submit the completed immunization record to the WPI Health Center. This immunization record must be signed by your health care provider before your arrival at WPI. Deadlines are August 15 for September enrollment and January 1 for January enrollment.

We understand and appreciate that all countries and states do not require the same immunizations as Massachusetts. However, the Massachusetts Department of Public Health is very specific regarding the immunizations required *of all students* attending institutions of higher learning in Massachusetts. All documentation must be in English.

*It is the law that all students be immunized in the following manner:*

- A. MMR (measles, mumps, and rubella):** Two doses separated by one month; first dose must be *ON OR AFTER FIRST BIRTHDAY*.

**OR (IF GIVEN INSTEAD OF MMR):**

**Measles (rubeola):** Two doses of live vaccine, one month apart, *ON OR AFTER FIRST BIRTHDAY*.

**Mumps:** Immunization with live vaccine *ON OR AFTER FIRST BIRTHDAY*.

**Rubella (German Measles):** Immunization with live vaccine *ON OR AFTER FIRST BIRTHDAY*.

- B. Tetanus/Diphtheria:** Three doses of Tetanus/Diphtheria are required; the last dose given within the past 10 years.

- C. Tuberculosis:** PPD (Mantoux) test within one year. *All students are required to show that they are free of tuberculosis. Having had BCG is not a substitute for testing nor is it acceptable proof of being tuberculosis free.* A chest x-ray is required if;

- the student has had tuberculosis
- has a positive (>10mm)
- or has a past known positive PPD.

If the student has had a positive tuberculin test, please indicate whether or not he/she received prophylactic medication.

Submit the Immunization Record prior to enrollment to  
WPI Health Center, 100 Institute Road, Worcester, MA 01609  
e-mail: [healthcenter@wpi.edu](mailto:healthcenter@wpi.edu)

STUDENTS WHO DO NOT SUBMIT THIS COMPLETED HEALTH EXAMINATION REPORT  
BY THE STATED DEADLINE WILL NOT BE PERMITTED TO REGISTER FOR CLASSES

## WPI HEALTH CENTER

### HEALTH EXAMINATION REPORT - PART A -

PLEASE PRINT OR TYPE

Date of Birth \_\_\_\_\_ S.S. # \_\_\_\_\_ Class \_\_\_\_\_  Male  Female

Name \_\_\_\_\_  
last first middle phone

Home Address \_\_\_\_\_  
number street city state zip

\_\_\_\_\_ e-mail \_\_\_\_\_ fax \_\_\_\_\_

Parents:  Married  Separated  Divorced  Widowed

Parent/Guardian/Spouse \_\_\_\_\_  
name(s)

\_\_\_\_\_ address \_\_\_\_\_ area code / telephone \_\_\_\_\_

Workplace \_\_\_\_\_  
address area code / telephone

Alternate responsible person *residing at a different address from above* to be contacted in case of emergency if parent/guardian unavailable.

\_\_\_\_\_ name \_\_\_\_\_ relationship \_\_\_\_\_

\_\_\_\_\_ address \_\_\_\_\_ area code / telephone \_\_\_\_\_

FAMILY HISTORY	AGE	STATE OF HEALTH	OCCUPATION	YEAR OF DEATH	CAUSE OF DEATH
Father					
Mother					
Brothers					
Sisters					
Spouse					
Children					
Give details of above					
_____					
_____					
_____					

Have you or any of your relatives had any of the following?	Yes	No	Relationship
1. Arthritis			
2. Asthma, allergy, hay fever			
3. Bleeding disorder			
4. Diabetes			
5. Epilepsy, convulsions			
6. Emotional disorder			
7. Heart attack before 60			
8. Heart disease			
9. High blood pressure			
10. Kidney disease			
11. Nervous muscular disorder			
12. Stomach disease			
13. Stroke			
14. Tuberculosis			
15. Breast cancer			
16. Other			

**Consent for treatment (required for students under 18):**  
 I hereby give consent for my minor child, \_\_\_\_\_  
 to receive routine care through the WPI Health Center and in the event of an  
 EMERGENCY, give permission to the Health Center and its affiliated hospital to  
 secure for this child appropriate treatment, including orders for surgery and anes-  
 thesia if necessary

**Consent for treatment (students over 18):**  
 In the event of an EMERGENCY, I hereby give permission to the WPI Health  
 Center and its affiliated hospital to secure for me appropriate treatment, includ-  
 ing orders for surgery and anesthesia if necessary.

\_\_\_\_\_  
 Signature of Parent or Guardian Print name of Parent or Guardian Signature of Student (over age 18)

